Rocky Mountain Medical Journal

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Vol. 47—No. 9
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COLE ON INTESTINAL OBSTRUCTION
ENELOW ON ALCOHOLISM — ROENTGEN THERAPY IN INTRACTABLE PAIN
MUMPS IN ADULTS — THYROID AND MENSTRUAL BLEEDING

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1. **CHLOROMYCETIN®is the first and only antibiotic** to be prepared synthetically on a commercial scale.

2. **CHLOROMYCETIN is rapidly effective in a wide range of infectious diseases,** including urinary tract infections, bacterial and atypical primary pneumonias, acute undulant fever, typhoid fever, other enteric fevers due to salmonellae, dysentery (shigella), Rocky Mountain spotted fever, typhus fever, scrub typhus, granuloma inguinale, lymphogranuloma venereum.

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Table of Contents

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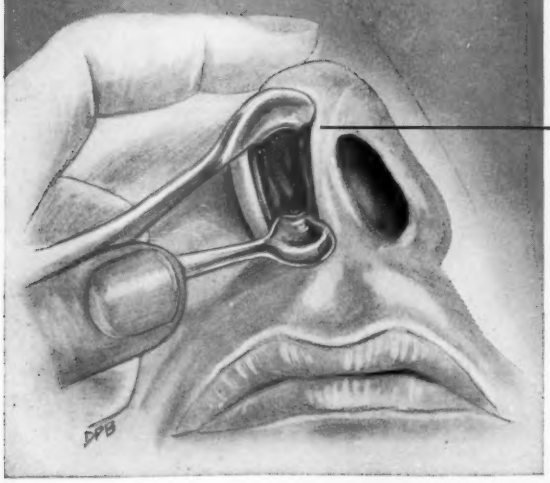
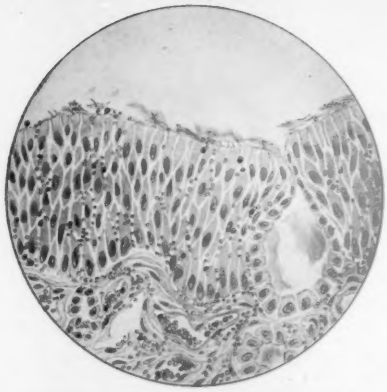
SEPTEMBER, 1950

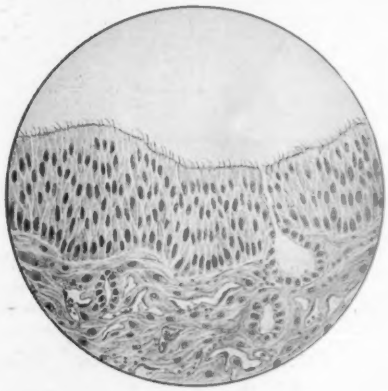
promotes
aeration . . . free drainage
in colds
. . . sinusitis





Nasal membrane showing increased leukocytes with denudation of cilia.

Normal appearing nasal epithelium.



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Manuscripts: Scientific Articles, Case Reports, etc., from any state for which this is the Official Journal should be submitted to the Scientific Editor for that state as named in the Editorial Board, above. Other material from any participating state should be submitted to the Associate Editor for that state as named above. Manuscripts from outside the Rocky Mountain area should be sent direct to the Journal office. Manuscripts must be typewritten, double or triple spaced, using only one side of each sheet. It is the policy of this Journal to omit bibliographies.

Advertising: National representatives: The Cooperative Medical Advertising Bureau, 535 North Dearborn Street, Chicago 10, Ill. Local advertising from firms in the Rocky Mountain area should be submitted to the Associate Editor of the appropriate state or to the Journal office. Advertising forms close on the 20th of the month preceding publication; allow ten days additional to insure submitting proofs for approval.

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THE COLORADO STATE MEDICAL SOCIETY

Next Annual Session: Broadmoor Hotel, Colorado Springs, September 20, 21, 22, 23, 1950

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(1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., Ann. Int. Med. 18:913 (June) 1943.
(2) Orent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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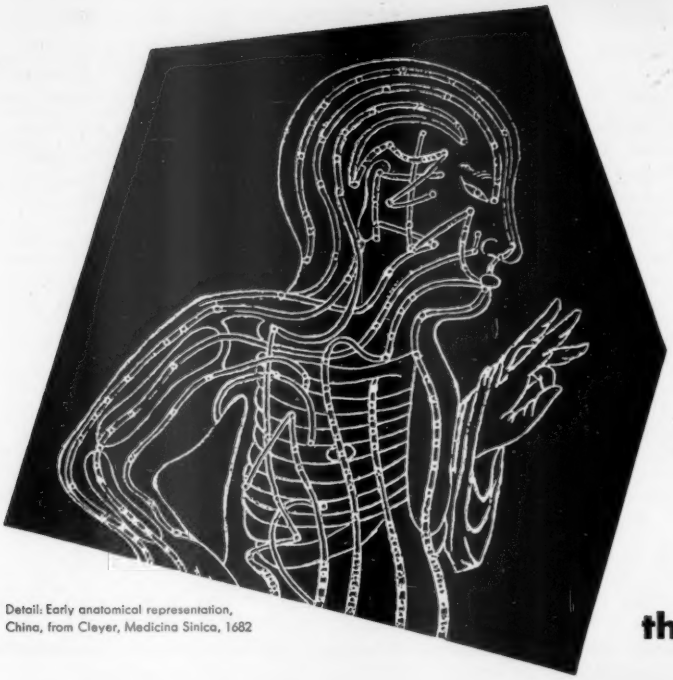

Detail: Early anatomical representation,
China, from Cleyer, Medicina Sinica, 1682

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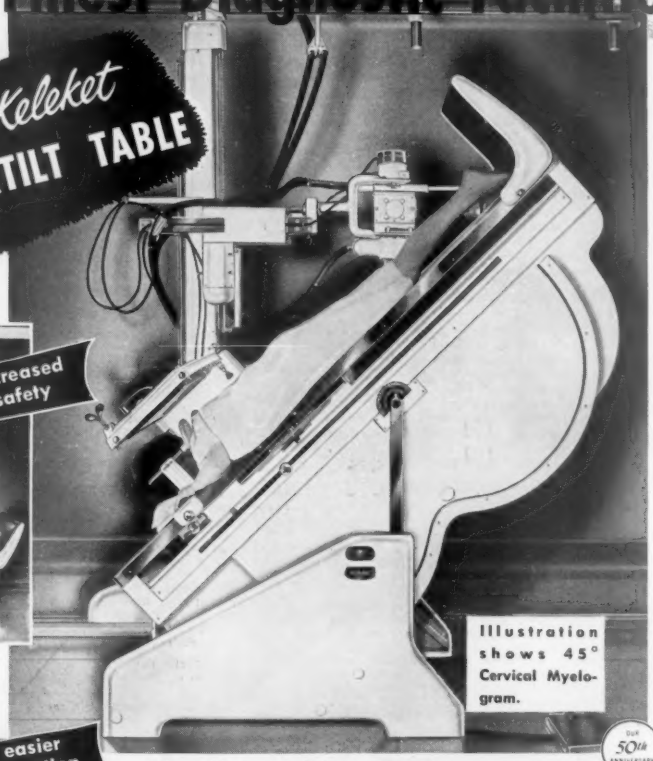

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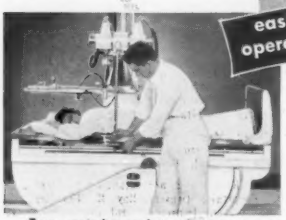

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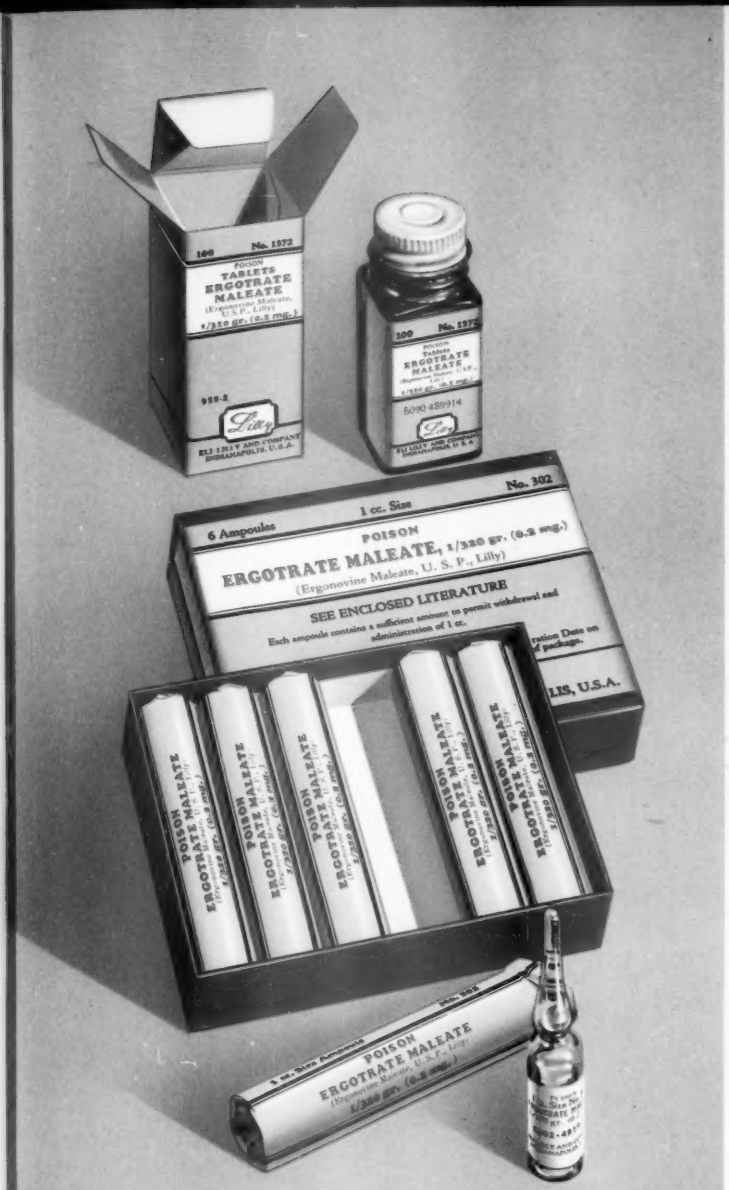

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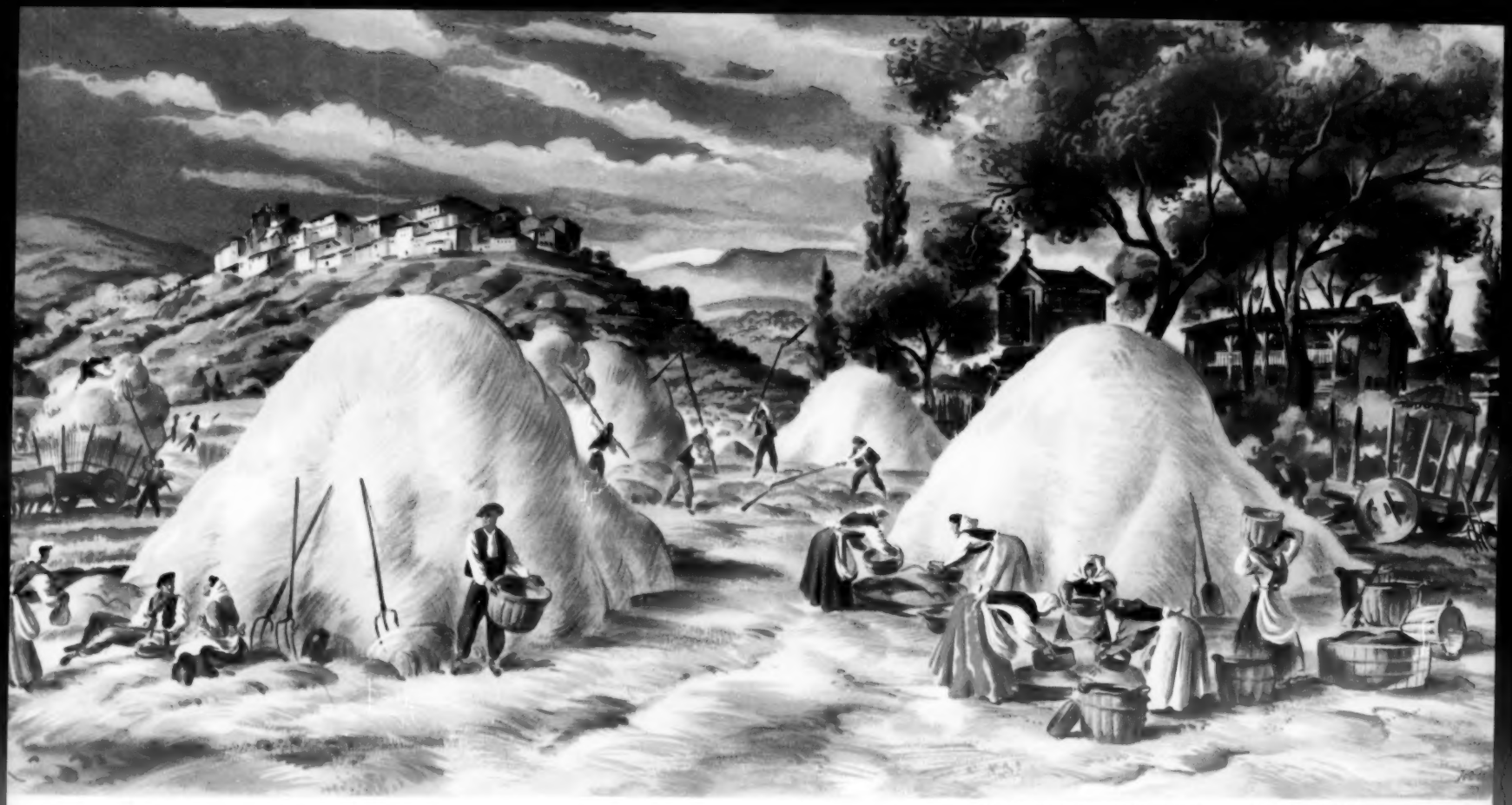

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SEPTEMBER
1950

Editorial

"The Menace of the Welfare State"

SEVERAL months ago (January, 1950) we published an editorial entitled "Dangerous Perception" which was based upon our belief that Dr. Lloyd Florio, Professor and Head of the Department of Public Health at the University of Colorado Medical Center, had seen what he wanted to see while touring England for the purpose of studying its prevailing system of medical practice. In our July issue, an article by the same author, entitled "The National Health Service of Great Britain" was published. An editorial footnote clearly stated that the article did not necessarily represent the opinion of this Journal, its editors, or the medical societies which it represents. We privately predicted that the article would "bounce," and sure enough it has.

For example, one of the comments in writing states, "In the last issue of the Rocky Mountain Medical Journal there was an article regarding socialized medicine in England with which I do not agree, having talked with doctors and laymen from England, and having read reprints from both doctors and laymen. I am enclosing a reprint from a British layman. Look it over. He does not seem to agree either." Our colleague in Montana enclosed a reprint of the article "The Menace of the Welfare State," by The Honorable Cecil Palmer, a distinguished Englishman who delivered the address before the Fifty-ninth Continental Congress, National Society, Daughters of the American Revolution, in Washington on April 20, 1950. His message was one of the most inspiring which has come to our attention.

The speaker stated that Americans do not seem to realize that they have liberty, whereas "my beloved people do not seem to realize that they have very largely lost it." They lost it by absenteeism at vital elections—the very thing that we are pleading that representative and thinking Americans must correct. Socialism comes to countries by default . . . and working classes don't run socialism, socialism runs them! There is very little welfare and a great deal of state about it. Socialism came to Great Britain, but under every other name but socialism—welfare state, planned economy, social security. The people voted for it because they were perplexed, bewildered and underfed, tired of the austerities of war. Now the nationalized industries have socialized souls and bodies of the men and women engaged in it. Seventy-four per cent of the lost working hours have taken place in the 20 per cent of nationalized industries. The Empire and the social order which has strangulated it does not possess a single shilling that has not been extracted from someone who has worked for it. No businessman or employer can do anything without permission of the government and he must abide by 20,000 orders, rules, and regulations which are law. Where, then, is freedom? Ten thousand governmental inspectors are traveling and snooping about to see that the rules are followed.

Socialism does not create wealth; it destroys it. It seems to endeavor to prove that you can legislate unsuccessful people into prosperity by legislating successful people out of it. It rejects the principles of statesmanship and accepts promises of politicians who tell the people that they shall have something for nothing. Time soon demonstrates that it doesn't add up.

British people find that living is now deadly dull. Look at the expressions on their faces and draw your own conclusions about whether the zest of living has not

been lost. Their eyes lack the luster of life, and everything in life is translated into bold economic terms. The elements of a welfare state which seem superficially to work out obviously do so only under compulsion. The people in a welfare state are handing their posterity liabilities, not assets.

Cecil Palmer went on to warn Americans that clever politicians get men and women exactly where the state wants them, and their stepping stone is socialized medicine. People at first are led to believe that the service is going to be free. Time demonstrates that nothing is free, not even the air. For example, there is only one radio in Great Britain, the British Broadcasting Corporation, whose governors are governmentally selected. Thus, freedom of the air is not granted to those who speak unfavorably about prevailing governmental management of anything. That same corporation, prior to vital elections, told the British people repeatedly and at all hours that medical care would be free. And now every man and woman, rich or poor, in England is paying for it. The few who can afford a private doctor therefore pay twice for the service. What price freedom?

Britain has lost over 50 million pounds already on nationalized industries, 20 million pounds on railroads alone, in one year. They have robbed Peter to pay Paul and are now coming to realize that Peter is dead.

For 2400 years doctors have taken the Hippocratic Oath, one of the tenets of which guards the privacy and secrecy between doctor and patient. But now in England under socialized medicine it is the duty of the doctor to make all records available to local lay councils and to the Minister upon demand. And the data are down on forms and more forms ad infinitum. There are no doctors on the lay councils and there is no such thing as a privileged communication.

England does not have enough doctors, nurses, clinics or hospitals to run the scheme. Some months ago there were over 200,000 institutional cases. When there are any empty beds it is usually because there are neither nurses nor doctors to serve them. In many communities the doctors must be responsible for the care of at least 4,000 patients in order to make a living. Realizing that satisfaction and inspiration is absent in such a practice many young men, if they desire to continue the study of medicine, intend to practice outside the country in which they are educated.

Socialism begins by soaking the rich and, having soaked, it begins the process of soaking the poor. The latter are those who rallied to vote for politicians who promised them everything for little or nothing; the former are those, in many instances, who did not appear at the polls.

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Let's Have More "Medical Politicians"

SEPTEMBER is a political month within as well as outside the medical profession. The Colorado, Utah and Wyoming State Societies all change administrations. It is the season, therefore, when delegates huddle over whom to select as elected leaders and when Presidents-elect ponder membership lists and past records of committeemen and get grey hairs before they can come up with new rosters of chairmen and other appointees to carry organized medicine's heavy load for another twelve months.

Unfortunately it is also the season when a few of our noisy but lazy brethren sneer the phase "medical politician" at those who would accept elected office or committee appointment. But these, whether they run for a state legislature, accept a medical society office, or simply serve on a workhorse committee, are the ones who are giving their own time, thought, energy, and and all too frequently their own money to advance the work of the whole profession and protect even those lazy brethren from the results of their own ennui.

So, we say, let's have more medical politicians, more candidates for office, more volunteers for committee jobs. By definition politics is the science of government. Our general body politic needs better government than it has recently had. Who's willing to help?

Original Articles

INTESTINAL OBSTRUCTION*

WARREN H. COLE, M.D.
CHICAGO

Every physician appreciates that intestinal obstruction is a serious disease associated with high mortality rate. Previous to development of decompression the mortality rate in a large series of cases would approach 30 to 35 per cent. Since the institution of decompression the mortality rate has dropped to about half that figure. However, it should be emphasized that unless extreme judgment and care are utilized in the care of decompression the mortality may actually be increased instead of decreased.

Intestinal obstruction is a fairly common condition being encountered frequently by all physicians except those in specialty fields. The relative frequency of the agents producing obstruction varies somewhat, depending upon the type of obstruction from which the figures are obtained. Perhaps the most common cause of intestinal obstruction is that produced by adhesions. About 32 per cent of all cases are caused by adhesions, three-fourths of which are the result of previous operations. Twenty to 24 per cent of all patients with obstruction will have strangulated hernias as the cause. The next most common cause is obstruction due to neoplasm, constituting 12 to 14 per cent.

In spite of an enormous amount of experimental work, there is still considerable controversy as to the explanation of toxicity encountered in intestinal obstruction. However, it is well known that dehydration associated with vomiting and lack of water intake is an important item in the disintegration of the patient's physical reserve. Likewise, hypochloremia is an obviously serious pathologic state associated with vomiting and lack of intake of electrolytes. However, it is well known that these two factors do not explain the serious toxic effects of the disease. The chief improvement in the patient's condition brought about by decompression and its consequent relief of distention lends important proof to the supposition that distention, itself, is an important factor in production of serious consequences. However, the mechanism is not clear. It is obvious that distention would impede venous flow, but perhaps with little or no obstruction to arterial flow. This condition would result in an accumulation of fluid in the intestinal wall, which becomes ischemic because of lack of circulation. It is obvious that this ischemia will result in serious cellular damage which, if present for more than a few hours, may conceivably give rise to accumulation of toxic by-products. If this explanation were correct, it would appear that the sudden release of an obstruction might result in rapid deterioration of the patient's physical condition. As a matter of fact, this sudden effect is noted, and has, no doubt, been encountered by every surgeon with considerable experience in intestinal obstruction. The serious effects noted are associated with a fall in blood pressure, tachycardia, and other manifestations of shock.

Diagnosis of Intestinal Obstruction

In the average case diagnosis will not be difficult and can usually be made over the telephone, if the physician asks the proper questions. However, since the manifestations are so different in high obstruction and low obstruction, the various points in diagnosis will be considered under these two types of obstruction.

High obstruction: Obstruction of the small intestine gives rise to fairly severe symptoms which are relatively characteristic. The first complaint is pain, which

*From the Department of Surgery, University of Illinois College of Medicine. Presented before the annual meeting of the Utah State Medical Association, Septmeber, 1949.

comes on as a cramp. However, it is not sufficient merely to ask the patient if he has been complaining of cramps, since very few patients actually know the definition of cramp. To be certain of correct interpretation of replies to our questions we should ask the patient if his pain comes on with moderate severity for a minute or two and then disappears for several minutes. This is the typical cramp brought on by persistaltic waves proximal to an obstruction. Shortly after the development of cramping pain the patient becomes nauseated and is apt to vomit. Constipation develops shortly after this, but it is not at all unusual to have two or three bowel movements after the development of the obstruction. Moreover, when the obstruction is not quite complete it is common to have a diarrhea with watery stools. The failure of the patient to pass gas may also be a definite signal of the development of obstruction.

Examination of the patient usually reveals evidence of severe illness if the obstruction is complete. The face is pinched with sunken eyes, and pallor is usually present. The amount of distention will depend upon the location of the obstruction. Obstruction in the pylorus or duodenum does not produce serious toxic effects other than those incident to dehydration. The amount of distention encountered in a patient with obstruction of the duodenum or pylorus is not very marked except in patients who have had chronic obstruction of increasing severity.

Inspection of the abdomen almost always reveals an intestinal pattern with peristaltic waves, unless the abdomen is obese. Percussion reveals an unusually tympanitic note and, with few exceptions, a marked increase in intestinal sounds will be heard on auscultation. The abdominal wall will be tense because of distention but in the absence of strangulation no muscle spasm will be noted. There may be numerous areas of moderate tenderness, or occasionally one area of tenderness, but the value of localized tenderness cannot be accepted literally as indicating the site of obstruction.

The x-ray will almost always be of great assistance in making the diagnosis, insofar as small intestinal patterns are visible if very much distention is present (see Fig. 1). Case 1 is an example of an obstruction of the small bowel produced by adhesions, resulting from a previous operation.

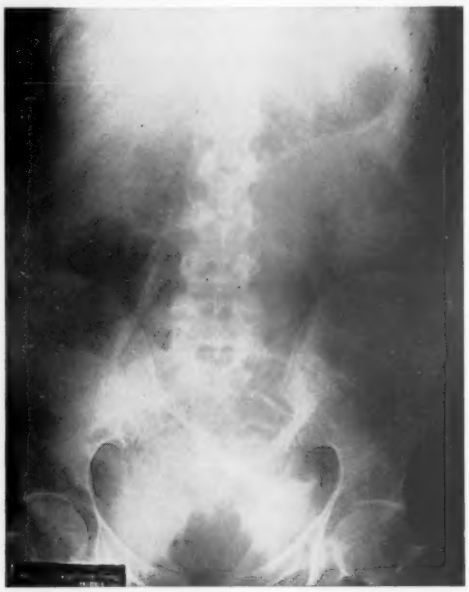


Fig. 1. Plain x-ray film of abdomen of patient (Case 1) having obstruction of the terminal ileum by adhesions. Note distended small bowel but absence of colonic haustral markings.

CASE 1

The patient, J. H., a female, aged 42 years, was admitted to the Illinois Research Hospital June 22, 1949, complaining of diarrhea of nine years' duration, diagnosed as sprue.

Past history: The diarrhea began twenty-four hours after drinking some unboiled water in Guatemala. After symptomatic treatment, the diarrhea subsided but began again about one year later. Within six months of the recurrence, she was having seventeen to nineteen watery bowel movements per day. In 1946, she noted carpopedal spasm for which she was given calcium gluconate with relief. Late in 1947, the diarrhea receded considerably. About one year later, however, she developed abdominal pain and vomiting for which she was operated upon in another hospital under the diagnosis of intestinal obstruction. About 30 inches of small intestine were resected. Following this she improved but by January, 1949, diarrhea had returned, and weight loss became pronounced.

Present illness: On September 19, 1949, she began rather suddenly to have acute epigastric pain which awakened her at 11:30 p.m. The pain was a typical cramp type, and was quite severe. She vomited an hour later.

Physical examination: Bowel sounds were hyperactive, and slight tenderness was noted in the mid-epigastrium without muscle spasm. Within two hours after onset, a slight distention was

noted. A Levine tube was inserted for decompression.

Within a few hours after onset, she had two bowel movements. A diagnosis of intestinal obstruction was made, adhesions being considered the most likely cause. X-ray of the abdomen showed large, dilated loops of small bowel. Within twenty-four hours after onset, the pulse had climbed slowly to 120, and the pain became more severe. Decompression was not at all satisfactory. The white count had risen to 12,000. It appeared that decompression was failing, and there was the probability that the blood supply of a loop of intestine was jeopardized. Accordingly, she was advised to have an operation.

Laboratory data: Gastric analysis revealed no free acid in the gastric secretions. The prothrombin test showed no clotting after 140 seconds. After one dose of vitamin K it returned to normal. The blood proteins varied between 4.3 and 5.3 gm. per 100 c.c., but there was no reversal of the albumin globulin ratio. There was much fat in the stool. The blood calcium varied from 7.0 to 8.5.

Operation: At operation on September 20, 1949, a loop of lower ileum was found to be herniated through some adhesions adjacent to the previous site of resection. The herniated loop was very dark, but upon release from the obstructing band, a good color returned. She tolerated the operation very well and made an uneventful recovery.

Low obstruction: When the obstruction is located in the large intestine the manifestations differ considerably from those described above. It is not fully appreciated that a complete obstruction of the large bowel can be present for as long as three or four days with absence of vomiting other than perhaps on one or two occasions. However, anorexia is almost universal in low obstruction. Nausea is less common. Distention is usually marked and, in fact, one of the early complaints noted by the patient. He may hear loud gurgling sounds which result from the increased peristaltic activity. Since dehydration and hypochloremia develop more slowly than in high obstruction, the toxic effects may be slower in developing. However, if distention develops rapidly and becomes pronounced, the patient's condition will deteriorate and he will show evidence of serious illness. As implied, previously, the serious manifestations are related to the distention.

Obstruction of the large bowel is usually located in the left side and is more commonly of malignant origin. In low complete obstruction, constipation and failure to pass gas develop early, and consequently will be of considerable diagnostic aid.

CASE 2

Patient M. E., female, aged 54, who entered the Illinois Research Hospital September 23, 1949, with the complaint of cramping abdominal pain of four months' duration and a weight loss of fourteen pounds during the past year.

Present illness: The patient was entirely well until one year ago when she developed slight constipation. The caliber of the stool was narrowed. It became necessary for her to use cathartics a great deal. About eight months after onset of the constipation, she noted development of generalized cramping abdominal pain accompanied by abdominal distention. She went to another hospital and was treated symptomatically. However, the symptoms persisted, and in the past few months have become worse. She was readmitted about eight weeks ago to an outside hospital where decompression and a series of enemas were given, but she was discharged apparently without a definite diagnosis. During the past four weeks, the bowel movements have been black. Two weeks before entry, she was diagnosed as having an obstruction and referred to our hospital.

Laboratory data: The urine was negative. The hemoglobin was 11.5 grams per 100 c.c., and the hematocrit 42 per cent. The serum albumin was 4.6 and the serum globulin 1.6 grams per 100 c.c.

Physical examination: The patient was still fairly well nourished in spite of a weight loss of 14 pounds. There was moderate abdominal distention. Examination of the abdomen revealed no masses or significant tenderness. There was no muscle spasm. Proctoscopic examination revealed no lesion although the scope could be inserted only 14 centimeters. A plain x-ray film revealed a distended colon (see Fig. 2); a barium enema revealed an obstruction in the sigmoid (see Fig. 3).

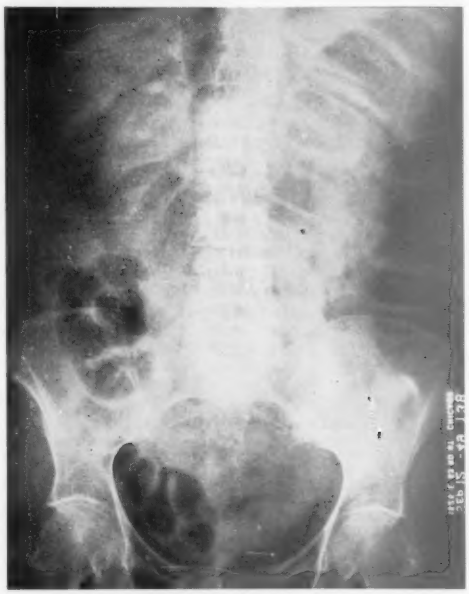


Fig. 2. Plain x-ray film of abdomen of patient (Case 2) having carcinoma of the sigmoid causing complete obstruction. Note distended loop of colon.

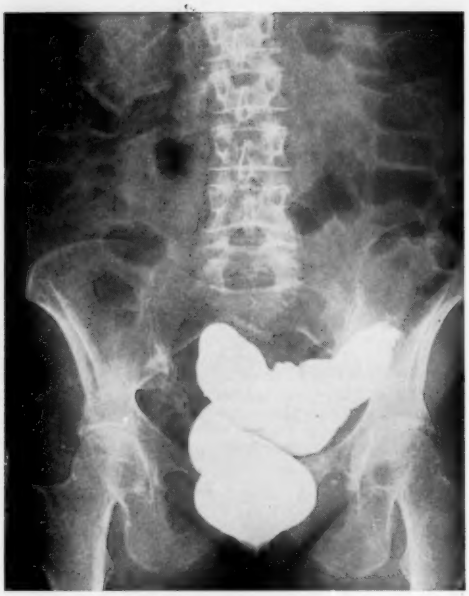


Fig. 3. X-ray film (with barium enema) showing complete obstruction of the sigmoid (Case 2).

A diagnosis of carcinoma of the sigmoid was made. The obstruction was considered to be almost complete although she was still passing gas and had a small amount of fecal material expelled following enemas. Since obstruction seemed fairly complete, it was decided that a primary resection would be ill-advised.

Operation: On September 26, 1949, a transverse incision was made in the epigastrium above the umbilicus. The lesion was located in the sigmoid opposite the umbilicus, but numerous nodules were noted in the mesentery adjacent to the bowel. Likewise, there were numerous small nodules in both lobes of the liver, which presumably were metastases. The lesion in the colon was annular and was obviously producing a serious obstruction. The colon proximal to the obstruction was widely dilated and contained an enormous quantity of fecal material. Accordingly, a primary resection and end-to-end anastomosis did not appear advisable. We brought a loop of transverse colon out through the wound, performing a loop colostomy.

Since metastases were present in the liver and the invasion along the wall of the colon was extensive, we did not believe a palliative resection was indicated. Therefore, she was discharged after recovery from the colostomy.

Diagnosis of Strangulation

There is slight difference of opinion as to the ease with which one is able to diagnose strangulation soon after the patient enters the hospital. However, the author is definitely of the opinion that except in 10 or 15 per cent of cases, strangulation can be diagnosed. It is quite true that during the first hour or two following admission to the hospital, manifestations may be confusing because the jolting and excitement related to the trip to the hospital may add to the complaints, including pain. After the patient has had an opportunity to rest and is properly assured by the physician, one can then usually obtain a fairly accurate assay of his condition.

Perhaps the most important single manifestation in the identification of strangulation is severe pain. As noted previously, the typical pain of intestinal obstruction is a cramp with intervals of freedom from pain. This cramp is not very severe and rarely indeed requires narcosis. However, when strangulation develops, pain increases tremendously and becomes constant, although there may be exacerbations of pain during peristaltic waves. This pain is so severe that the patient commonly asks for sedation. Such symptoms as nausea and vomiting are not increased in intensity with strangulation. An increase in pulse rate is fairly universal and presumably is caused in part by the increase in pain, and in part by the increase in toxicity. Tenderness is almost always more pronounced in strangulation and may be more localized over the diseased area. Muscle spasm likewise is usually present.

A mass may be encountered on examination, although commonly it will be difficult to detect because of muscle spasm. The mass usually consists of the strangulated loop which becomes very distended.

If a moderately large loop of intestine is involved in the strangulation, evidence of shock may develop early because of two factors. In the first place, if obstruction of venous flow takes place before obstruction to the artery, as will usually be the case, a large amount of blood may be impounded in the involved loop. The loss of this blood to the circulating volume may be sufficient actually to result in a decrease in blood pressure. In addition to this factor is the development of toxic by-products. These by-products are not so apt to be absorbed from the intestine into the circulation itself, but are absorbed from the peritoneal cavity when fluid escapes through the wall of the intestine into the free peritoneal cavity after the development of strangulation.

Treatment of Intestinal Obstruction

As already stated, decompression has recently been shown to be of great value in the treatment of obstruction. Some types of intestinal obstruction can be treated effectively by decompression alone, others need an immediate operation, as will be discussed below.

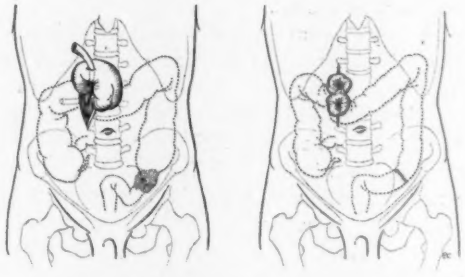
Decompression therapy: Decompression alone will be effective in relieving paralytic ileus as well as intestinal obstruction due to adhesions. It is particularly effective in the relief of obstruction occurring during the first few days following operation. In most types of obstruction, as discussed later, decompression cannot be used as definitive treatment, although it can be used in all patients (regardless of the type of obstruction) to evacuate the stomach and upper small intestine. Evacuation of the stomach will result in a much smoother anesthetic when the operation is performed.

Unfortunately, it will frequently be very difficult to identify adhesions as the cause of the obstruction. Paralytic ileus is much easier to diagnose, since it almost always occurs after operation and is associated with a silent abdomen. On the other hand, practically all other types of obstruction give rise to increased peristaltic sounds. The history of a previous operation or severe inflammation can be very helpful in arriving at the diagnosis of adhesions. Obviously the absence of a previous operation or inflammation will be of more diagnostic value insofar as obstruction by adhesions can usually be excluded in these patients.

Since obstruction due to adhesions is relatively uncommon when the large bowel is involved, one should assume that large bowel obstruction is due to some cause other than adhesions.

Along with institution of decompression, administration of fluids should be started immediately. If vomiting has been very significant, and intake of food and water had been diminished for quite some time, it will be essential to give two or three liters of fluid in the first few hours. Likewise, if vomiting is pronounced and the patient is relatively young with a good pair of kidneys, the first two or three liters should consist of sodium chloride with glucose. However, before any fluid is given, blood should be drawn for estimation of the blood chloride level. As soon as this figure is obtained an approximation can be arrived at relative to the amount of salt needed. Likewise, an approximation as to the amount of fluid can be obtained since the amount of urine excreted after a few hours' observation will be important in determining the amount of fluid indicated.

As implied, the exact diagnosis as to the cause of obstruction will not always be apparent. If obstruction of the large bowel (e.g., carcinoma), and strangulation can be excluded, then one can consider decompression for several hours as a preliminary method of treatment, realizing that operation may be indicated at any time. If decompression is going to be effective, certain results should be demonstrable. For example, the amount of fluid obtained through the tube should be profuse. The distention should decrease in amount; likewise, the pain should decrease in severity. Nausea and vomiting will, of course, disappear because of the presence of the tube. If a tachycardia is present, and not associated with strangulation, it also should disappear. Release of the obstruction itself usually requires several hours; perhaps the first evidence of release would be passage of gas



Colostomy for obstruction, resection later, multiple stages.
(Necessary only in left or transverse colon.)

Fig. 4. When complete obstruction of the colon (usually on left side) is present, an immediate colostomy, as shown on the left, is indicated because decompression rarely is of any benefit in relieving the obstruction. Delay in performance of colostomy may allow rupture of the cecum which is a serious complication usually resulting in death, even though early operation is performed to exteriorize the perforated area. About two weeks after performance of the colostomy, the tumor can be resected and a primary end to end anastomosis performed as illustrated on the right. The colostomy is closed later by a spur crushing procedure.

by the patient; shortly after that, a spontaneous stool or effectual enema may be obtained.

Operative treatment: Space does not permit the inclusion of operative technic in this presentation; however, there are certain principles which I would like to emphasize. In the first place, operation should never be performed until dehydration and electrolytic deficiency are corrected, at least to a slight degree. When strangulation is obviously present and the patient's condition is critical, we do not wait for complete restoration of fluid and electrolytic balance. In such patients, transfusions will be indicated before operation is completed. Since fluids can be administered during the anesthetic and during the operation, we are therefore willing to start the operative procedure before complete restoration of balance, since it is so urgent to relieve the patient of strangulation.

When the obstruction is located in the large bowel, early operation will be strongly indicated, but rarely indeed is it permissible to direct attention to the lesion itself. It is much better to perform a colostomy (e.g., right or left transverse colostomy), delaying the treatment of the obstructive lesion for ten to fourteen days (see Fig. 4). Obviously, if the patient has a volvulus, or evidence of strangulation of the large bowel, attention must be directed to the obstructive lesion.

In any operation for intestinal obstruction, the amount of manipulation must be held to a minimum. Likewise, the operating time should be reduced as much as possible, since most of these patients are in critical condition. Resecton of the strangulated loops with primary anastomosis is desirable. However, if the patient's condition is critical, it may be wise merely to exteriorize the loops, performing resection with establishment of continuity later. The bowel adjacent to obstructed areas is usually edematous and friable; anastomoses in such areas are dangerous because of danger of leakage. Accordingly, when resection is being performed, it should be sufficiently radical to remove the edematous friable intestine, and thus allow placement of the suture line in relatively healthy bowel.

The Book Corner

New Books Received

The Cerebral Cortex of Man (A Clinical Study of Localization of Function): By Wilder Penfield, C.M.G., M.D. (Johns Hopkins), B.Sc. and S.Sc. (Oxon.), Hon. F.R.C.S. (Lond.), F.R.S., Professor of Neurology and Neurosurgery, McGill University; Director, Montreal Neurological Institute; and Theodore Rasmussen, M.D., Professor of Neurological Surgery, The University of Chicago; formerly, Lecturer in Neurosurgery, McGill University; Assistant Surgeon, Montreal Neurological Institute. The MacMillan Company, New York, 1950. Price, $6.50.

Maternity Care in Two Counties: Gibson County, Tennessee, Pike County, Mississippi, 1940-41, 1943-44: Frank E. Whitacre, M.D., Chief, Division of Gynecology and Obstetrics, The University of Tennessee College of Medicine; and Ellen Whiteman Jones, M.P.H., Statistician, The Commonwealth Fund. The Commonwealth Fund, New York, 1950.

The Mask of Sanity: An Attempt to Clarify Some Issues About the So-Called Psychopathic Personality. Non teneas aurum totum quod splendet ut aurum. Alanus de Insulis: By Hervey Cleckley, M.D., Professor of Psychiatry and Neurology, University of Georgia School of Medicine, Augusta, Georgia. Second Edition. St. Louis, The C. V. Mosby Company, 1950. Price, $6.50.

Saints, Sinners and Psychiatry: Camilla M. Anderson, M.D., Assistant Clinical Professor of Psychiatry, University of Utah. Philadelphia-London-Montreal, J. B. Lippincott Company. Price, $2.95.

Essentials of Ophthalmology: Roland I. Pritikin, M.D., F.A.C.S., F.I.C.S., Eye Surgeon, Rockford Memorial, Winnebago County and Swedish-American Hospitals; Consulting Ophthalmologist, St. Anthony Hospital, Rockford, Ill.; 215 Illustrations, including 18 subjects in color. Philadelphia-London-Montreal, J. B. Lippincott Company. Price, $7.50.

Book Reviews

Quinidine in Disorders of the Heart: By Harry Gold, M.D., Professor of Clinical Pharmacology at Cornell University Medical College, Attending-in-Charge of the Cardiovascular Research Unit at the Beth Israel Hospital, Attending Cardiologist at the Hospital for Joint Diseases, Managing Editor of the Cornell Conferences on Therapy. Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers. Price, $2.00.

This small monograph, extremely well written as it is, presents in concise fashion a summary of the uses of quinidine in the treatment of heart disease. The first portion of the book is devoted to the indications, pharmacology, therapeutic actions of quinidine, and to the problems of dosage, both for the treatment of arrythmias and their prophylaxis. The rational basis for the use of quinidine in each of the disorders of rhythm is then taken up separately in the succeeding chapters, with discussions of the physiologic mechanisms involved, the therapeutic objectives, modes of action, dosage and toxicity of quinidine. Many valuable clinical observations are also included.

This volume is obviously based upon the extensive personal experience of the author not only in pharmacology but in the treatment of heart disease. Everyone who treats heart disease, be he a general practitioner or an internist, will find this book highly informative and pleasant reading. Many will want copies for their own libraries.

H. HAROLD FRIEDMAN.

ALCOHOLISM*

PROBLEMS OF TREATMENT AND RESEARCH

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TOPEKA, KANSAS

It has been estimated that fifty million people in the United States use alcoholic beverages, that three million drink excessively, and that 750,000 could be classified as chronic alcoholics.[1] The size of the problem is further indicated by the studies of Landis. He calculated that in 1940, the wage loss due to alcoholism was $432,000,000; that 70,000 alcoholics moved in and out of county and local jails daily; and estimated the cost of care of alcoholics in mental hospitals alone as $13,000,000 a year, or $2,600 per patient. The total yearly cost of medical and hospital care for alcoholism is estimated to be $31,000,000.[3] These estimates are undoubtedly conservative.

It is only in the last hundred years that abnormal drinking has been considered a medical problem. Although a few people have always looked on alcoholism as a medical problem, no systematic attempts to treat alcoholism are on record prior to the first half of the Nineteenth Century. Indeed, the treatment of alcoholic addiction was generally punitive until recently.[10] The punitive attitude still persists in legislation and in the minds of many physicans. Yet alcoholism is a medical problem and without doubt is not solved with punishment.

Every physician comes in contact with alcoholism. Alcoholism can be, and often is, a factor in convalescence from disease, in incidence of infectious disease, deficiency diseases and, indeed, can complicate any medical problem. But alcoholism is also a problem in its own right. The anguish of the family of the alcoholic patient, the destructive effect of the behavior of the alcoholic on his children, associates, and the community at large is vast. We are beginning to understand the alcoholic better. Some approaches to treatment and research are beginning to suggest themselves, but we have much to learn.

*Presented to the New Mexico Medical Society, Las Cruces, N. M., May 4, 1950. From the Topeka State Hospital, Topeka, Kansas.

Acute Alcoholism

Acute alcoholism primarily represents a problem in medical treatment. While its psychiatric implications are important in studying the nature of alcoholic addiction, its treatment usually takes place in the general hospital. It is well known that the important toxic effect of ethyl alcohol on man is on the central nervous system. The action of significant concentrations of alcohol in the central nervous system is one of depression, and later paralysis, of function. The earliest phenomenon seen in acute intoxication is an increase in general activity of the organism. This appears to be a release phenomenon due to the paralysis of higher inhibiting neural centers. Higher concentrations of alcohol affect progressively lower centers and if sufficient alcohol is ingested, death may occur from depression of the respiratory center in the medulla oblongata. The concentration of alcohol necessary to produce fatal results varies with the individual. In chronic alcoholism a tolerance to alcohol develops. Also the lethal concentration of alcohol is lower as blood sugar is lowered.[7]

The diagnosis of acute alcoholic intoxication is relatively easy to make. The treatment varies with the degree of drunkenness and with the general state of nutrition and hydration of the patient. Thus, in mild drunkenness little more than rest and sedation may be indicated. The "cocktail party" type of drunkenness requires a good night's sleep. However, the larger medical problems are posed by the chronic alcoholic, who usually presents himself to the physician in a state of drunkenness with tremulousness, anxiety, perhaps impending delirium tremens, and most often, in a state of poor nutrition and hydration. In such cases the patient should be put to bed immediately. Sedation is generally necessary at first and paraldehyde has been found the most effective sedative. However, it must be cautioned that if doses are too high, or if

paraldehyde is continued too long, the alcoholic patient will find that he enjoys it as much as his favorite brand of bourbon. Therefore, if continued sedation is required, chloral hydrate should be substituted for paraldehyde within three days of the patient's admission. One should always strive to remove the patient from all sedation as soon as possible. The patient's hydration must be attended to at once so that intravenous sodium chloride solutions should be begun as soon as the patient is quiet enough to make such administration possible. Intravenous glucose is indicated and, in fact, as the blood sugar is elevated, the symptoms of alcohol intoxication become mitigated. Fifty c.c. of 50 per cent glucose may be given intravenously immediately, or if fluids are being given, 10 per cent glucose in normal saline may be administered in amounts up to 3,000 c.c. a day, depending on the state of hydration. Insulin improves the condition of the acutely alcoholic patient and up to 25 units of regular insulin three times a day can be given, covered, of course, by an appropriate amount of glucose. If respiratory failure threatens, the inhalation of 10 per cent carbon dioxide without rebreathing will stimulate the respiratory center and may prevent death from respiratory failure. High doses of thiamine chloride and other vitamins should be given, particularly in the presence of polyneuropathy or in the presence of some of the other organic alcoholic disorders.

Alcoholic Addiction

The most important psychiatric problem of alcoholism is that of the alcohol addiction itself, which can and should be differentiated from chronic over-indulgence. The so-called "usual picture" of the alcoholic really does not exist, in my experience. There are abnormal drinkers from every walk of life and some are, in fact, successful people. Alcoholism is seen in psychotic patients, in patients with neurotic symptoms, in patients with psychopathic personalities, and in patients who have no other clinical psychologic syndrome — the so-called essential alcoholic. There are drinkers who have long periods of sobriety between drinking bouts and others who drink continuously until a hospital or jail prevents them from doing so. There are drinkers who like the taste of alcoholic beverages and others with alcoholism equally severe who do not enjoy its taste. It becomes apparent that alcoholism is a symptom or symptom-complex and not in itself a disease.

The treatment of alcohol addiction, thus, varies with the individual and his personal problems, so that it seems inappropriate to search for one avenue of approach. There are, however, some points of psychology in common in all chronic alcoholics which are important in determining many aspects of the approach to treatment. For example, when treatment becomes uncomfortable for them, if it is at all possible, they will drink. This fact complicates all treatment and has resulted in the conclusion most workers in the field have reached—that for treatment to be successful the patient must be physically kept away from alcohol. Alcohol has the quality of giving some degree of relief from the pain of facing the demands of reality and from the psychic pain that results from emotional conflict. All alcoholics have emotional conflict with underlying insecurity and feelings of inferiority. The chronic alcoholic has a deep-seated fear of some unspeakable and horrible terror, which he attempts to escape by drinking. Alcoholics are individuals who continue to view the world as the infant does whose most important avenue of contact with his environment is his mouth.[6] We have all noticed the approach of the infant to his outside environment—namely, that he wants to put everything that he can in his mouth. Soon in infantile development, the baby tries to destroy with his mouth anything which resists his demands. Drinking involves a rather typical infantile revenge reaction of this sort. The alcoholic overvalues the mouth and pleasures of the mouth. Like the infant in its first year, he wants to "take everything in" that is to be cared for and loved without the necessity for him to earn that love through assuming responsibility and giving love. His rage at the environment which fails to give him

what he wants is great and is expressed again in an "oral" way. By drinking, he brings unhappiness upon his family and ruin upon himself and them. That the discomfort of the family of the alcoholic is of positive value to him in pursuing his self-destruction is one of the most important elements in the psychology of alcoholism. One might characterize the unconscious feeling as "I'll kill myself and then they'll suffer and be sorry." The alcohol also suppies the oral love in symbolic form in the liquor itself, and in actual form in the friendship and comradeship which accompanies social drinking.[6]

What has happened in the personality development of the alcoholic that leaves this seriously incapacitating infantile remainder in his personality? Dr. Karl A. Menninger[6] believes that the early disappointments which we all suffer have, in the case of the alcoholic, been actually greater than the person could bear and have affected his personality development so that, emotionally, he remains at this early stage. As a child he had feelings of insecurity, inferiority, frustration with resulting rage, fear, and guilt. In adulthood these feelings remain, though the patient may not be conscious of them, and may be compensated for by nomadism, aggressive driving behavior, conscious feelings of superiority to other people and in many other ways.

The Treatment of Alcohol Addiction

Systematic treatment for alcohol addiction began little more than a hundred years ago. There were few efforts, however, to do much more than punish the patient.[10] In recent years, two approaches have become apparent, one of them with drugs and the other with psychotherapy. Jellinek,[1] as a matter of fact, considers drug treatment versus psychotherapy one of the main issues in treatment. I am not at all certain that this is an either-or problem. However, it is apparent that since the whole personality is involved, it is unlikely that any approach will be widely successful if it does not aim at changing the patient's personality in one way or another.

Many authors consider the ideal treatment a combination of hospital treatment giving, among other things, a physical removal from alcohol, and psychoanalysis or some other form of psychotherapy. All therapists believe that absolute abstinence must be maintained in the course of the treatment and almost all therapists believe that the patient must become a total abstainer.

The greatest difficulties encountered in treatment are the attitude of the patient and those intimately associated with him. The patient fears confinement, fears losing his alcoholic escape from reality, and fears the stigma of having been in a mental hospital. The family is usually angry, feeling that the patient is spiting them (and with some justification), but yet frequently help defeat treatment by developing a peculiar pathologic optimism which has been noted by Dr. Karl A. Menninger. This is really self-deception used by the patient and the family to escape the necessity of effecting a truly thorough-going change in the patient. The alcoholic's friends usually plead with him, most doctors whom he encounters are cynical, clergymen sentimentally attempt to inspire the patient, social agencies generally scorn him or are paralyzed by feelings of hopelessness, and jails and some hospitals treat him brutally. None of these attitudes make for effective treatment.[11]

Individual psychotherapy with alcoholics, in itself, has not been notably successful. In an outpatient situation it has, in fact, been notably unsuccessful with all but a few very well-motivated patients. One of the reasons is that successful and thorough-going psychotherapy is emotionally painful, which stimulates alcoholics to drink. Results with psychoanalysis have been interesting and suggestive. However, they have not reported a greater percentage of successes than any other treatment approach. In addition, the length of time involved, the expense, and the shortage of psychoanalysts make this unlikely to be an effective solution. The psychoanalysis of alcoholics will, however, continue to give us further insight into the psychology of the alcoholic patient, which will help show us what we must do to help them. Shorter, less thorough, ap-

proaches to individual psychotherapy have been used fairly successfully in hospital situations. It is an interesting fact that most workers, using almost any kind of approach, list between 40 per cent and 50 per cent successes with a systematic program. The length of the follow-up studies is frequently in question, however.

Group psychotherapy appears to have value in the treatment of alcohol addiction. Here, the ability of the alcoholic to relate himself better to other alcoholics than he can to non-drinkers is capitalized upon. In group therapy, attempts are made to illuminate for the patient his significant problems so that he can try to understand and correct them. Much can sometimes be done in groups to give the patient a feeling that he is being supported in his efforts to conquer alcoholism. The most successful of all group approaches has been Alcoholics Anonymous; it utilizes a group comradeship and mutual help approach. We consider the prognosis somewhat better when a patient joins A.A. after leaving the hospital.

The most widely used pharmacologic approach to alcoholism, with or without psychotherapy, is the conditioned reflex (or aversion) treatment.[4 8 9] This treatment aims to produce a reflex vomiting or disgust on tasting an alcoholic beverage. The most frequently used technic is that of Voegtlin and Lamere who use emetine hydrochloride as an emetic agent to set up the conditioned reflex. Other workers have used apomorphine, and others ipecac in the liquor. The conditioning is done by a series of sessions in which the emetic agent is used to provoke the temporal effect of vomiting immediately upon ingestion of alcoholic liquor. After this experience has been repeated, the emetic agent is no longer necessary and vomiting will occur reflexly. This treatment has many serious drawbacks. If used alone and nothing is done about correcting the personality defects, the patient is likely to consciously break down the conditioning or he may turn to other kinds of alcoholic beverages. Thimann gives six or seven single re-enforcing conditionings over a period of a year after treatment and claims 50 per cent "cures."[8 9] The Shadel Sanitarium group have reported supplementing their aversion treatment with psychotherapeutic efforts. They claim better than 60 per cent "cures."[4] We have had some experience with conditioned reflex treatment and find that the conditioned reflex itself is relatively easy to produce. It is too early for us to evaluate our results with this treatment, but we have had one patient who sat down immediately after completing treatment to systematically abolish the reflex and left the hospital to continue his alcoholism.

One of the most recent developments in drug treatments of alcoholism is the new drug Antabuse*, or tetraethylthiuram disulphide.[2 5] Antabuse in itself is only mildly toxic. Taken orally, it may produce drowsiness and at times gastro-intestinal complaints, as well as other mild to moderate symptoms. When the patient is actively at work it is much less likely to produce these symptoms. However, when Antabuse reacts with alcohol, acetaldehyde is formed in the blood. A patient receiving Antabuse who takes a drink containing alcohol will get severe symptoms of acetaldehyde toxicity. This involves first a flushing of the face and neck, later a feeling of pressure in the head, palpitation, dizziness, weakness, and a feeling of impending doom. The later symptoms are those of cardiovascular collapse with low blood pressure, rapid thready pulse, and an ashen-gray pallor. Some patients even go into shock. A few patients have, in addition, nausea and vomiting. These symptoms may last from two to six hours. With repeated experiences the reaction occurs sooner after drinking and lasts longer.

This drug should only be given in the hospital. It should only be given after careful physical and laboratory studies to see if patient is in good physical condition. Two or three fatalities have occurred, possibly due to improper management. After the patient has had two or three experiences with the effect of drinking alcohol, he may be discharged from the hospital to remain on a daily maintenance dose of Antabuse.

*Antabuse, or tetraethylthiuram disulphide, has been supplied by Ayerst, McKenna and Harrison, Ltd.

He is warned not to drink, and in fact even a dram of cough syrup in an alcoholic vehicle will produce mild toxic symptoms.

Our experience with this drug is still comparatively short. Some investigators have given it up because they feel that it is potentially too dangerous. Others have great faith in the drug. Our group has utilized group and individual psychotherapy in addition to Antabuse with certain patients. It is too early to evaluate results, but certain things have become evident. Some patients exploit the mild symptoms of discomfort from their maintenance doses of Antabuse and are unable to work. Others begin to want to stop taking the drug because they feel it makes them too uncomfortable. And, of course, any patient can stop taking the Antabuse tablets. Sometimes the family can be enlisted to see that the pills are taken, but this is not different from the family's usual attempts to remonstrate with the patient about his drinking. Its effect will likely be the same antagonism toward the family. Whether Antabuse will make it more possible to treat the alcohol addict remains to be seen.

In the opinion of our group, it will be necessary to develop a many-pronged approach to the treatment of alcoholism, using drugs in some cases as a physical barrier to taking liquor and attempting through psychotherapy, either individual or group, to correct the personality defects that are really the cause of alcoholism. We are at present studying conditioned reflex and Antabuse treatment, in addition to hypnotherapy and psychotherapy based on psychoanalytic principles.

Research Problems

It is interesting to compare the funds available for research and treatment in alcoholism with other major diseases:[11]

Tuberculosis	68,000 cases	$130,000,000
Polio	175,000 cases	16,000,000
Cancer	500,000 cases	5,000,000
Alcoholism	750,000 cases	500,000

Despite this, however, some excellent research on alcoholism is going on and more is in prospect.

We must learn more about the psychology of the alcoholic. We must test different therapies for alcoholism under controlled conditions and gather more data. We must try to find, if we can, what effect the treatment has on the psychology of the patient. We must examine without bias all treatment approaches presented on a rational basis or in which some claims for success have been made. We must not, however, think that we know, as yet, why a given treatment fails or succeeds. Lengthy follow-up studies are necessary and, if possible, we must try to follow those patients whom we study for periods of two to ten years. One of our greatest problems at present is to get the funds necessary to make such research feasible. The problem is expensive to the individual and to the community. Research would cost far less than is spent on alcoholic beverages by drinkers. Alcoholism is a serious medical problem. It is a serious social problem. It is more baffling than almost any other problem in psychiatry.

What we must do in order to eventually conquer the problem of alcoholism is to educate the community to sympathetic understanding of the problem and to a realization of its true importance. We must educate social agencies and state and federal agencies to the importance of subsidizing research and treatment of alcoholism. We must make medical treatment available for acute alcoholism and we must make psychotherapy accessible to low income groups.[11] Most important, as physicians we must acquaint ourselves with as many of the aspects of alcoholism as possible.

REFERENCES

[1]Bowman, Karl M. and E. M. Jellinek: Alcohol Addiction and Its Treatment, in Jellinek, E. M.: Effects of Alcohol on the Individual, I. Alcohol Addiction and Chronic Alcoholism, New Haven. Yale University Press, 1942, p. 49. ff.

[2]Glud, Erik: The Treatment of Alcoholic Patients in Denmark With "Antabuse." Quarterly Journal of Studies on Alcohol, 1949.

[3]Landis, Benson Y.: Some Economic Aspects of Inebriety, in Alcohol, Science and Society, New Haven. Quarterly Journal of Studies on Alcohol, 1945, p. 201 ff.

[4]Lamere, F. and P. O'Halloren: Treatment of Chronic Alcoholism by Intravenous Barbiturates. N. W. Med., 48:482, July, 1949.

[5]Jacobsen, E. and O. Martensen-Larsen: Treatment of Alcoholism With Tetraethylthiuram Disulfide. J. Amer. Med. Assn., 139:918-922, 1949.

[6]Menninger, Karl A.: Man Against Himself. Harcourt Brace & Co., New York, 1938, pp. 160-184.

[7]Newman, Henry W.: Acute Alcoholic Intoxication.

Stanford University, Stanford University Press, 1941, 107 ff, 182 ff.

[9]Thimann, Joseph: Conditioned Reflex Treatment of Alcoholism. I. Its Rationale and Technic. New Eng. J. Med., 241:368, 1949.

[10]Thimann, Joseph: Conditioned Reflex Treatment of Alcoholism. II. The Risks of Its Application, Its Indications, Contraindications and Psychotherapeutic Aspects. New Eng. J. Med., 241:406, 1949.

[11]Voegtlin, Walter L. and Frederick Lamere: The Treatment of Alcohol Addiction. Quarterly Journal of Studies on Alcohol, 2:717, 1942.

[12]Yahraes, Herbert: Alcoholism Is a Sickness. Public Affairs Pamphlet No. 118, New York.

THE RELIEF OF INTRACTABLE PAIN BY ROENTGENTHERAPY*

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DENVER

The value of roentgentherapy in the management of intractable pain is too little appreciated generally. Within certain limited spheres of pathological conditions, the relief afforded the sufferer of severe pain is often rapidly accomplished, occasionally in a degree that can be termed dramatic, leading one to wonder that more use of roentgentherapy for this purpose is not made. There exists a need for dissemination of information to physicians relative to the pain relieving effects of roentgentherapy. The earliest roentgentherapists became aware of the analgesic effect of roentgen irradiation, but the organic effects have been stressed to the medical student to the exclusion of the symptomatic. It can properly be said that in some conditions with intractable pain there is as yet no adequate substitute for the analgesic effect of roentgen irradiation.

Limitations of use of roentgen irradiation for relief of intractable pain cannot be overemphasized. Roentgen irradiation is a powerful agent which, if used without discrimination or if not kept within its proper therapeutic boundaries, may produce undesirable serious permanent changes in other tissues than those which it is desired to effect. Used without adequate care, or neglectfully, lesions could be produced by roentgen irradiation which could ultimately be as distressing as, or even more so than, the original lesion. For this and other reasons, only one who is trained and experienced in radiation therapy should undertake such treatment. Used in excess, roentgen irradiation can create conditions which foster extension of inflammation—used in too small quantities, it may not be effective. However, within its proper spheres, it is often the best analgesic known. It is common for patients to tell the roentgentherapist following roentgen irradiation that they are having relief to the extent that they are able to have a good night's rest again for the first time since the pain began. Roentgen irradiation often has a great advantage in that it may not only bring relief of pain, but may, and usually does, have a direct curative influence simultaneously, the degree of which may vary between minor and major degrees of magnitude.

The mechanisms by which roentgen irradiation affects tissues in accomplishing relief of pain are not yet thoroughly understood. Most widely accepted theories indicate (1) liberation of antitoxic and antibacterial substances from leucocytes whose destruction is accomplished through roentgen irradiation, (2) the effects of roentgen irradiation on the circulation in producing early dilatation and later constriction of the blood vessels in the field of treatment, and (3) retardation of cellular proliferation. When bacteria are present there is little or no effect directly due to irradiation on the bacteria themselves, but these bacteria are usually affected by the substances liberated from the destroyed leucocytes. In malignant conditions relief of pain can usually be explained on the basis of reduction in size of the tumor mass.

Limitations arising from the effect on normal tissues preclude use of radiation therapy solely for alleviation of pain except in intractable cases in which other simpler therapeutic agents have not been effective, and for those types of cases where the effectiveness of radiation therapy is so

*Presented at the University of Colorado Postgraduate Course in Regional Anesthesiology, June 28, 1949. From the Department of Radiology, University of Colorado Medical Center, Colorado General Hospital, Denver.

striking as to present itself as the outstanding means of analgesia. Dosage limitations further restrict use of roentgen therapy for palliation and analgesia. Such considerations vary in individual circumstances and cannot be a subject of detailed discussion here. However, the need for a properly trained and experienced radiologist in any consideration of dosage, particularly because of possible effects on neighboring tissues and organs, is signally evident. Where pain is associated with extensive scar tissue, roentgentherapy is usually contraindicated.

Certain considerations of a general nature in the application of roentgentherapy for relief of intractable pain require elaboration. These considerations are particularly applicable in herpes zoster, radiculitis, sciatica, cervical neuritis, and Marie-Strumpel arthritis. These considerations are:

1. Age—More immediate and lasting relief is obtained in younger individuals.

2. Stage of disease—The earlier treatment is given, the better the result.

3. Early exacerbation—A favorable sign following shortly after the first or second treatment.

4. Single doses must not be too large lest they cause harm, particularly in infectious processes.

5. Inadequate effectiveness of treatment in alleviation of pain during or immediately following an adequate course of treatment is not to be construed as an indication for additional therapy lest the bounds of safety be overstepped.

One of the prime indications for the use of roentgentherapy for intractable pain is found in herpes zoster. Over 85 per cent of cases treated within the first few days of vesiculation can be cured. After the first two weeks of the disease the percentage is lowered, approximately 50 per cent of successes with treatment by roentgentherapy. Treatment of an aged patient whose pain has endured for four weeks or more is very often unsatisfactory. In the early case, in the young individual, relief is usually obtained after the second treatment and sometimes earlier. Because there may be an early exacerbation of pain, which is a favorable indication, the patient should be instructed as to this possibility and to continue the treatment to the end of the series should exacerbation develop. Treatment is dircted to the involved ganglia, daily for six days, in moderate dosage.

Another prime indication for roentgentherapy is the Marie-Strumpel type of arth-itis, also known as rheumatoid arthritis of the spine, an arthritis whose early manifestations appear in young individuals usually initially in regions which may not suggest, at first thought, disease of the spine. Often the pains are first noted in the extremities. Alertness to the possibility of Marie-Strumpel arthritis should lead to the proper diagnosis and to early roentgentherapy, in two or three courses of small series of treatments, as the most effective modality in alleviation of pain and arrest of the disease process.

Bursitis, particularly in the acute stages, responds well to a small series of light roentgentherapy. The chronic type also often responds. Certain types of parotitis, plantar warts, and medulloblastomas of the brain are usually best treated with roentgentherapy.

Recently we have treated two cases of painful aphthous stomatitis with spectacular relief and without recurrence. Pain in this condition was relieved shortly after the first treatment in each case, one patient reporting that he was able to sleep well for the first time in two weeks. It is logical to expect good response to radiation therapy in aphthous stomatitis for virus diseases are responsive.

Malignancies form a large percentage of the cases for which roentgentherapy is used to alleviate intractable pain. A prime indication is metastatic bone disease. The limited use to which roentgentherapy can be put in metastatic neoplastic bone disease for alleviation of pain is never to be forgotten for its effectiveness is striking. In fact, it is justifiable to irradiate a painful bone on suspicion of metastasis in certain known cases of carcinoma before roentgenographic confirmation of the metastasis is present.

The more radiosensitive the tumor, the more effective is the treatment, but the therapeutic test should be applied to all. In painful bone metastases arising from breast carcinoma in premenopausal females, it is well to bear in mind that roentgen castration is usually effective in relief of bone pain over a period of six to twelve months as a rule.

It is also well to bear in mind, should other means fail, that painful furuncles, such as on the upper lip and ala nasi, often respond dramatically to a single small dose of roentgentherapy.

Summary

The roentgentherapist has a definite position on the team working to overcome pain. The indications for roentgentherapy set forth are worth bearing in mind for in many instances roentgentherapy is the treatment of choice. Its effect is usually not limited to the control of pain but, properly used, also may strongly influence the course of the disease processes, probably by the mechanisms above described.

REFERENCES

1. Carty, J. R., and Bond, L. M.: Amer. Jnl. Roentgen. 46:532, Oct., 1941.
2. Freyburg, R.: M. Clin. N.A. 30:603, May, 1946.

THE INTERNATIONAL COLLEGE OF SURGEONS

The International College of Surgeons, United States Chapter, will hold its fifteenth Annual Assembly and Co vention in Cleveland, Ohio, October 31, November 1, 2, 3, 1950, according to George M. Curtis, M.D., Columbus, Ohio, Chairman of the Assembly.

The program will include scientific sessions on subjects in the fields of general surgery; eye, ear, nose and throat surgery; gynecology and obstetrics; urology; and orthopedic, thoracic, plastic and neurological surgery. In addition, an extensive technical and scientific exhibit will be presented by leading manufacturers of surgical instruments, x-ray apparatus, operating room and hospital equipment, pharmaceuticals and others, Dr. Curtis said. Special entertainment for the doctors' ladies has been planned.

Arnold S. Jackson, M.D., Secretary of the United States Chapter, has reported from Madison, Wisconsin, that several hundred surgeons will be received as Associates and Fellows of the International College at the Convention to be held in the Cleveland Public Auditorium, November 3.

All doctors of medicine interested in surgery and its advancement are invited to attend, and can obtain a program upon request to Arnold S. Jackson, M.D., Secretary, Jackson Clinic, Madison 4, Wisconsin. For hotel reservations, contact Committee on Hotels, International College of Surgeons, U. S. Chapter, 511 Terminal Bldg., Cleveland 13, Ohio.

Case Reports

THE PREVENTION OF MUMPS IN ADULTS

PRELIMINARY REPORT

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BOULDER, COLORADO

A widespread epidemic of mumps occurred in Boulder, Colorado, during 1949 and early 1950. A number of adults who had never had epidemic parotitis and who had been thoroughly exposed to the disease when relatives developed it presented themselves for immunization. The group treated is small, but now that the epidemic has passed results are presented for what they are worth. None of the seven patients developed symptoms of mumps during thirty days following exposure.

CASE REPORTS

Case 1: T. K. S., male, aged 64, weight 182 pounds; 10 c.c. of immune human globulin were given four days after exposure.

Case 2: M. T., male, aged 50, weight 190 pounds; 9 c.c. of immune human globulin were given two days after exposure.

Case 3: K. F., female, aged 20, weight 123 pounds; 10 c.c. of immune human globulin were given five days after exposure.

Case 4: C. B., male, aged 41, weight 153 pounds; 10 c.c. of immune human globulin were given the day after exposure.

Case 5: R. R., male, aged 24, weight 185 pounds; 10 c.c. of immune human globulin were given two days after exposure. A second case occurred in the household. A booster dose of 4 c.c. of immune human globulin was given fourteen days after the first dose.

Case 6: W. B., male, aged 21, weight 170 pounds; 10 c.c. of immune human globulin were given seven days after exposure.

Case 7: E. M. C., male, aged 32, weight 227 pounds; 10 c.c. of immune human globulin were given two days after exposure to first case in his family. A second and a third case developed, and he was given a booster dose of 4 c.c. immune human globulin fourteen days after the first dose of 10 c.c.

Case 8: J. C., male, aged 44, weight 150 pounds; 8 c.c. of immune human globulin were given two days after exposure.

Results

There have been no failures; all the cases have been adequately followed. The immune serum globulin used in these cases was prepared by Cutter Laboratories from blood donated to the American Red Cross

and provided for civilian use. It contains 160 mgm. of gamma globulin per c.c. The preservative is sodium ethylmercurithiosalicylate 1:10,000. I see no objection to the use of globulin prepared from placentas. The sources of error in a short series such as this are the low communicability of the disease and the possibility of unrecognized previous attacks. Further experiments would be necessary to estimate the minimum effective dose, should the validity of these observations be verified.

THE THYROID AND MENSTRUAL BLEEDING*

JOSEPH B. DEISHER, JR., M.D.
WINDSOR, COLORADO

It is the purpose of this paper to reemphasize the frequent association of excessive uterine bleeding with hypothyroidism. A mistaken, but apparently commonly held, concept is that a decrease in menstrual flow is associated with a decreased basal metabolic rate and that metrorrhagia occurs with hyperactivity of the thyroid. Mazer and Israel state, "Metrorrhagia is the more frequent menstrual disorder of primary hypothroidism. The latter may appear with or without goiter." Waters and Williams reported five cases of excessive uterine bleeding in women with low BMR, relieved by administration of thyroid. More frequent recollection of this association would perhaps prevent needless surgery in women of the childbearing and menopausal periods. While this paper was being prepared, Barnes reported treatment of various menstrual disorders with desiccated thyroid. Of fifty cases of excessive bleeding, two failed to improve, two others improved, and forty-six resumed periods with normal flow. He records forty-five patients whose chief complaints were of irregularity of menstrual cycles. Of these, two failed to respond to thyroid, two improved, and forty-one became regular. Correction of concomitant fatigue, large sleep requirement, nervousness, irritability, poor appetite, and underweight was noted.

*Read before the regular meeting of the Weld County Medical Society in June, 1950.

Therapeutic trial of thyroid therapy may, in many cases, obviate the necessity for curettage or hysterectomy, especially in young women, based on the "exclusion diagnosis" of uterine fibrosis or functional hyperplasia of the endometrium. Thyroid medication is much more acceptable to the patient, much less costly, and when indicated, much more effective than an extended and expensive series of injections of one or other of the hormone preparations.

An adequate level of thyroid activity often develops following pregnancy, especially if two or more pregnancies have occurred in quick succession. Frequently this deficiency, due to exhaustion of the thyroid gland, is first called to the patient's attention by uterine bleeding of excessive volume associated with headache and an unwonted lassitude, which is often erroneously attributed to the resultant anemia and to the postpartum state.

The headache is severe, bursting in character, increasing to throbbing with exertion, and is unrelieved by the usual analgesics. Stilbestrol, in doses of 0.5 mg. once or twice a day, may give marked relief in an hour or two.

The bleeding may be of a flooding nature so profuse as to soak through double perineal protection in less than one hour and even suggest the possibility of abortion. Of this symptom, also, stilbestrol may result in control within a short time.

Ease of fatigue ranges from the level of "just tired all the time" to the point where the patient is forced to nap in the afternoon or drops off to sleep in a chair without previous excessive activity during the day. Stilbestrol has no effect on this tiredness which occurs all through the menstrual cycle.

The level of adiposity is consistent only in being usually abnormal—either too great or too little—with continuing progress in the direction of the abnormality. On one hand, the patient gains weight or "never loses the weight put on during pregnancy." On the other hand, more than a few of these women are overly slender, hyperkinetic, and nervously irritable. The history of sud-

den onset of obesity following delivery of a child is commonly obtained from overweight women. Occasionally, obesity will develop on a hypothyroid basis as a result of the psycho-sexual readjustment entailed in marriage itself.

In conjunction with the manifestations mentioned above, the multitudinous vague, annoying, but not disabling symptoms of hypothyroidism occur singly, or in any combination, to assist in the diagnosis. The intractability of the hair under the beautician's comb, the coarsening and dryness of the skin, the sensitivity to cold, the brittleness of the nails are too well known as symptoms of hypothyroidism to need further mention here. The basal metabolic rate or the level of blood cholesterol is used to confirm the clinical opinion and give a rough estimate of the degree of thyroid inadequacy. Frequently, the BMR is within the lower limits of the "normal" range, i.e., -10 to -5 per cent, but the response to thyroid therapy indicates that it is defintely below normal for that patient.

Physical examination reveals no sharply diagnostic features, but the combination of obesity or nervous slenderness with thickened dry skin, dry hair, cracked finger nails, low pulse pressure, and rarely the presence of thyroid enlargement substantiates the diagnosis of hypothyroidism. Pelvic findings are minimal, consisting only of some tenderness of the adnexal tissues, which may be due to co-existing pelvic inflammatory disease. The uterus itself is not enlarged as a result of hypothyroidism, nor is there consistent palpable abnormality of the ovaries.

Pathological examination of the endometrium reveals a normal or very slightly hyperplastic architecture, with no obvious reason for the increase in bleeding.

The following cases will serve to illustrate the points mentioned:

CASE 1

E. A., a 26-year-old para 1, gravida 1, had been somewhat overweight for several years and experienced moderate difficulty in conceiving until her weight was decreased by diet and desoxyphedrine. There had been some evidence of vitamin B inadequacy prior to her pregnancy. Her periods were regular every 29-30 days, lasting four days. After a loss of 31 pounds in three months, she noted that her menstrual periods consisted of spotting only. Reduction was then discontinued and she returned eight months later, seven weeks pregnant. The pregnancy was normal and she nursed the baby two weeks. Upon recommencing menstruation her periods were irregular, frequently flooding, and accompanied by headache and general feeling of malaise and tension. A BMR at that time was minus 15 per cent. She was started on thyroid, desiccated, ½ grain b.i.d. This was later increased because of persistent fatigue to 1 grain b.i.d. and the periods became regular at thirty-two days, lasting four days.

CASE 2

I. N., a 23-year-old nullipara, experienced menarche at age 13. The first two periods lasted two weeks each, were quite profuse, and accompanied by cramps. She became regular and continued so, until at age 15, she had three months of amenorrhea subsequent to an appendectomy. This was followed by regularity at five-week intervals until age 20, when she had an episode of prolonged spotting. Two weeks after marriage, she flowed profusely for two weeks. She then received a series of injections of an undetermined nature over a period of six months. These would slow down the flow for two days at a time. She finally refused to return and received no more treatment for about twelve months, during which she got along fairly well. When markedly excessive bleeding returned, she consulted another physician. A BMR on March 24, 1948, was minus-6 and she was placed on thyroid, with resultant normal menses. She then voluntarily stopped medication and within two months had another episode of flooding uncontrolled by stilbestrol and ergotrate. She was hospitalized and transfused. Curettage was performed and resulted in only a small amount of tissue, which was reported as normal endometrium in early secretory phase. Bleeding stopped promptly and thyroid therapy was re-instituted. Two months later, having voluntarily stopped medication for a second time, she again bled excessively. She was treated with testosterone with relief and the necessity for continuation of thyroid medication was impressed upon her. She was placed on an obesity regimen. One year later, though not very greatly reduced in weight, she reported that she was taking thyroid, 2 grains daily, and that her menses had been well regulated for the last eight months.

CASE 3

M. E. D., 32-year-old para 4 (1942, 1943, 1946, 1947), who had always been very energetic and active, noted after the third delivery that she was inclined to put on weight. All pregnancies were normal except for pyelitis with the first, difficult vaginal deliveries with the first two, and caesarian section for each of the last two; with cornual tubal ligation at the time of the last section. She was unable to nurse the last two babies more than two weeks each. When menses reappeared, the interval was the usual twenty-eight to twenty-nine days, but the flow was so copious as to run down her legs on arising from bed in the morning. The periods were heralded and accompanied by severe characteristic headache and often lasted seven to ten days. Her weight began to increase and she

noted such severe lassitude that she would fall asleep while reading or sewing in the afternoon. A BMR one year after delivery was minus-8. Stilbestrol controlled the headache, but caused some nausea and vomiting. Disiccated thyroid, ½ grain twice a day, regulated the menses of about thirty-three days' interval and five days' duration and average flow. The headache did not occur while taking thyroid. After four months of thyroid therapy, the patient voluntarily discontinued the medication for three weeks following a period, recommencing on advice. The next period was very profuse and accompanied by headache. Since resuming regular uninterrupted thyroid intake, she has had no more trouble.

CASE 4

N. A., a 36-year-old para 6, white widow, was first seen on June 23, 1947, with menstrual bleeding every two weeks with headache and dizziness. Her difficulty was ascribed to a chronic inflammation of the pelvis and treatment with large doses of vitamin B complex seemed to result in improvement. She was seen again on February 2, 1948, with the same complaints, however, and it was learned that she had previously taken 2 grains of thyroid daily. Pelvic examination still showed marked adnexal tenderness. She was given diathermy to the pelvis and thyroid therapy was reinstituted.* Two weeks later, the cervix was cauterized and she healed well. For the next year, her main complaint was of dizziness more marked around the time of her menses which were irregular and profuse. She was taking the thyroid only sporadically at this time. On February 16, 1949, the patient was seen again with profuse menstruation and severe headache. She was referred to a surgical consultant who suggested injections of Antuitrin S and, if no improvement resulted, recommended hysterectomy. With the next period on March 7, 1949, Antuitrin S was started. Because of reaction to this material, and because of severe headache, the patient was told to start thyroid again, at 5 grains a day and the necessity for constant regular administration was emphasized. The next period was normal except for mild headache and since then on a dosage of 6 grains of desiccated thyroid daily she has had normal periods and only very slight headaches and one short episode of dizziness associated with a few days' lapse in medication and has felt well.

CASE 5

D. F., a 22-year-old para 3 (1945, 1946, and 1948), was first seen on May 10, 1949, with complaint of headache and profuse menstrual bleeding and cramps. She weighed 125 pounds (height 61 in.) until her first pregnancy, during which she lost weight and delivered prematurely at seven months. She threatened abortion with both the others, but was carried through to term. Since the last delivery, she had had marked irregularity with the last three periods about six to eight weeks apart. With the last period, she passed numerous clots. On examination her weight was found to be 94 pounds, pulse 80, BP 94/62. Her colon was tender, her breasts atrophic, the skin dry. Her left ovary lay in the cul de sac; the cervix was everted, hypertrophic and chronically infected. She was started on thyroid with marked improvement in menses and in general well being. After two months, she voluntarily stopped taking the thyroid regularly and quit completely in August. Her periods promptly became profuse and irregular and the former lassitude returned. She was again placed on thyroid medication with instruction to continue taking it faithfully and she has again improved in weight, working ability, menstrual function, and general well being.

*BMR was not determined because of financial reasons.

Comment

The cases cited were given various forms of treatment including injections of hormones, vitamins and estrogens by mouth, and surgery. Surgery was suggested in another, but was forestalled by proper use of thyroid medication.

Summary

1. Attention is drawn again to the relationship of excessive uterine bleeding to hypothyroidism.

2. A syndrome associated with hypothyroidism and including menorrhagia, headache, and marked lassitude is described.

3. Five cases showing this syndrome are described.

4. The advantages of thyroid medication over hormonal injections and surgery are pointed out.

ARTHRITIS AND RHEUMATISM FELLOWSHIP

The Arthritis and Rheumatism Foundation is offering fellowships for research in the basic sciences related to the study of arthritis. These fellowships carry a stipend of from $4,000 to $6,000, depending upon the needs and ability of the worker, and run for a period of one year. The fellowships would begin in July, 1951, although earlier appointments would be considered by the committee.

The Foundation is anxious to back a candidate, rather than a project, an institution, or a hospital. It hopes to arouse interest in arthritis in a wider circle of medical investigators and to encourage able, inquiring minds.

Applications should be sent to the Arthritis and Rheumatism Foundation, 535 Fifth Avenue, New York 17, New York, by January 1, 1951. Notification of the fellowships granted will be made March 1, 1951.

If any applications are received by September 15, 1950, they will be acted on at that time and notification made immediately.

That older persons now constitute the major focus of tuberculous infection is emphasized by recent autopsy studies which show that a relatively large number of persons supposedly succumbing to diseases other than tuberculosis were found to have this disease in active form. It is recognized that the disease in older persons is frequently mild and that the symptoms may be overlooked.—Statistical Bull., Metropolitan Insurance Co., November, 1948.

Organization

National Affairs - Proceedings - Programs - Society Notices - News - Auxiliary

COLORADO
State Medical Society

PROGRAM—WOMAN'S AUXILIARY TO THE COLORADO STATE MEDICAL SOCIETY

September 21 and 22, 1950

The twenty-eighth Annual Convention of the Woman's Auxiliary to the Colorado State Medical Society will be held during the time of the State Medical Society Convention in Colorado Springs, Thursday and Friday, September 21 and 22, at the Broadmoor Hotel. A cordial invitation is extended to all Auxiliary members and wives of guests of the State Medical Society to attend all meetings and planned social functions.

AUXILIARY PROGRAM

Thursday, September 21

9:00 A.M.—Registration.
Meeting of Executive Committee.

10:00 to 12:00 Noon—All Membership Workshop Conference.

10:00 A.M.—Interpreting the:
American Medical Association and the Auxiliary—Mrs. Kris Peterson, Administrative Assistant, Coordination and Public Relations, A.M.A., Chicago.

State Medical Society and the Auxiliary—Dr. McKinnie L. Phelps, Chairman, Public Policy Committee, Member Advisory Committee to Auxiliary.

County Medical Society and the Auxiliary—Dr. W. Wiley Jones, President, Denver County Medical Society.

11:00 A.M.—"We Earn the Future"—Panel Discussion—State President and Chairmen with an evaluation of year's projects and development of technics for Auxiliary work. Workshop will be closed with a question and answer period.

12:30 P.M.—Auxiliary Luncheon. Sponsored by Woman's Auxiliary of Pueblo, honoring 1949-50 County Presidents and Past State Presidents.
Style Review—Courtesy presentation by Montaldo's, Hotel Broadmoor.

1:30 P.M.—Pre-Convention Meeting of the Board of Management. For outgoing State Officers, Chairmen, County Presidents and all Past State Presidents.

3:00 to 5:30 P.M.—Reception and Tea for all Doctors' Wives attending the Convention. Hostesses: Woman's Auxiliary of Colorado Springs, Mrs. Walter C. Herold, Chairman. Home of Dr. and Mrs. James W. McMullen, 1528 Wood Ave., Colorado Springs. Hostesses will furnish transportation to Tea from and to the Broadmoor Hotel.

8:00 P.M.—Ice Show at the Broadmoor Ice Palace. Auxiliary is the guest of the Colorado State Medical Society.

Friday, September 22

9:00 A.M.—Registration.

9:45 to 12:00 Noon—Annual Business Session.
In Memorium.
Recognition of new County Auxiliaries.
Election of Officers.
Installation of Officers for 1950-51.

12:30 P.M.—Annual Auxiliary Luncheon. Sponsored by Woman's Auxiliary of Weld County. Honoring our National President of the Woman's Auxiliary and the State Board of Management. Guest Speaker: Mrs. Arthur A. Herold, Shreveport, La., National President, Woman's Auxiliary to the American Medical Association.

2:00 P.M.—Joint Meeting with the Colorado State Medical Society, Broadmoor Little Theatre. Guest Speaker: "The A.M.A. and the War," Dr. Ernest B. Howard, Assistant Secretary, American Medical Association.

3:00 P.M.—Post Convention meeting of Newly Elected State Board of Management.

4:15 P.M.—"They Also Serve"—Film. Time, 20 minutes. Broadmoor Little Theatre. Sponsored by Auxiliary.

7:00 P.M.—Annual Banquet (dress optional).

Saturday, September 23

Recreation Day!
Tour of Broadmoor area and Will Rogers Shrine. Tour of Garden of the Gods.
Available sports activities: golf, swimming, ice skating, boating, tennis, fishing and horseback riding.

Auxiliary Luncheons—Main Dining Room.
Auxiliary Meeting in Southeastmoor.
Board of Management Meeting in Children's Dining Room, Main Building.

PROGRAM FOR THE ANNUAL MEETING OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS

The meeting will be held September 24, 1950, at the Broadmoor Hotel, Colorado Springs, Colorado.

September 23

6:30 P.M.—Dinner meeting.

September 24

9:00 A.M.—"Traumatic Rupture of the Bronchus With Repair"—Donald L. Paulson, M.D., Associate Professor of Thoraic Surgery, Southwestern Medical College, Dallas, Texas.

10:00 A.M.—"Bronchial Asthma and Conditions Which Simulate It"—Leon Unger, M.D., F.A.C.C.P., F.A.C.P., Associate Professor of Northwestern University Medical School, Attending Physician at Cook County and Wesley Memorial Hospital, Chicago, Illinois.

11:00 A.M.—"The Value of Bronchoscopy in the Study of Thoracic Diseases"—Bruce E. Douglass, M.D., Department of Endoscopy, Mayo Clinic, Rochester, Minnesota.

12:00-2:00 P.M.—Luncheon—Round Table Discussion. "The Future of A.C.T.H. in Pulmonary Disease." The discussion led by Dr. Pfuetze, Dr. Unger, and Dr. Douglass.

2:00 P.M.—"The Place of Chemotherapy and Antibiotics in the Management of Tuberculosis"—Carl H. Pfuetze, M.D., Medical Director and Superintendent of the Mineral Springs Sanatorium, Cannon Falls, Minnesota.

3:00 P.M.—"Surgery in Pulmonary Tuberculosis"—Thomas J. Kinsella, M.D., Associate Professor of Surgery, University of Minnesota.

4:00 P.M.—"Decortication of the Lung for Empyema and Tuberculosis"—Julian A. Moore, M.D., Chief of Surgical Service, St. Joseph's Hospital, Ashville, North Carolina; Consulting Thoraic Surgeon, Veterans Hospital, Oteen, North Carolina.

All physicians invited—no registration fee.

SOUTHWESTERN SURGICAL CONGRESS

The Southwestern Surgical Congress has just announced the completion of the scientific program for its second annual meeting which will be held in Denver, with headquarters at the Shirley Savoy Hotel, on September 25, 26 and 27. An outstanding scientific program is being presented. Among the guest speakers will be Dr. R. W. TeLinde, Professor of Gynecology at Johns Hopkins University; Dr. Thomas A. Kinsella, Professor of Thoracic Surgery at the University of Minnesota; Dr. James D. Rives, Professor of Surgery at the L.S.U. Medical School; Dr. Robert W. Buxton, Associate Professor of Surgery at the University of Michigan; Dr. Ferdinand C. Helwig, Pathologist to St. Luke's Hospital in Kansas City, Missouri; Dr. Willis W. Brown, Professor of Gynecology at the University of Arkansas; Dr. Harwell Wilson, Professor of Surgery at the University of Tennessee; Dr. Carl A. Moyer, Professor of Surgery at the Southwestern Medical School; Dr. Julian Moore, Senior Consulting Surgeon of the Veterans Administration, Ashville, N. C.

Topics of current major surgical interest will be discussed. A large attendance is expected as membership in this organization covers nine states. Non-member physicians and surgeons in this area are cordially invited to attend. Dr. Ralph M. Stuck, Republic Building, Denver, Colorado, is chairman of local Arrangements Committee and all inquiries and reservations may be made through him.

News Notes

NORTHEAST COLORADO

At the regular May 11 meeting of the Northeast Colorado Society at Sterling the following officers were elected for the 1951 year: President, H. P. Linton; Vice President, L. W. Anderson; Secretary-Treasurer, K. H. Beebe; Board of Censors, Frank Palmer; Delegates, E. A. Elliff, R. W. Ralston; and Alternates, Jack Naugle and John Lundgren.

Following the business meeting a Golden Anniversary Dinner in honor of Doctors Hummel and Daniels was enjoyed by members and guests of the society. Dr. Jack Naugle showed pictures of a recent trip to Hawaii. Dr. C. I. Tripp showed pictures of a trip to Mexico and R. W. Ralston of a Caribbean cruise.

Obituary

SALING SIMON

Dr. Saling Simon, well-known Denver internist, died August 4, 1950, in his suite in the Brown Palace Hotel.

Doctor Simon attended City College of New York and received his medical degree in 1895 from Gross Medical College. He took postgraduate work in London, Berlin, and Vienna between 1908 and 1914. Upon his graduation from Gross Medical College he began practice in Denver. He was the first secretary of the Medical Advisory Board of the National Jewish Hospital in 1899 and was Medical Director in 1917 and 1918. Doctor Simon was a Captain in the Medical Corps of the United States Army during World War I.

Doctor Simon was a member of the American Medical Association, Denver and Colorado Medical Societies, a fellow of the American College of Physicians, certified specialist of the American Board of Internal Medicine, chief resident physician for Denver General Hospital, instructor in physical diagnosis for the Gross Medical College from 1897 to 1904, and a staff member of Mercy, Presbyterian, and Beth Israel Hospitals.

NEW MEXICO
Medical Society

News Notes

Dr. W. R. Lovelace, II, Albuquerque, Chairman of the Aeromedicine Panel of the Scientific Advisory Board to the Chief of Staff of the United States Air Force, is now touring Europe to investigate and to keep abreast of the developments in aviation medicine and in surgical technics. He is scheduled to give several lectures on "Congenital Surgical Lesions of the Neck, Their Diagnosis and Treatment."

Dr. Lovelace was in Copenhagen, Denmark, August 15-18, attending the meeting of the 18th International Physiological Congress.

Dr. Lovelace was quoted in a New York newspaper as saying, "Medically and civically, we (the Air Force) are in an excellent position to meet any requirement that may develop." He further stated that this applied to both Korea and any possible larger war.

In World War II Dr. Lovelace, a Colonel, served as Chief of the Aero Medical Laboratory at Wright Field.

UTAH
State Medical Association

Obituaries

ERNEST WHITNEY OLDHAM

Dr. Ernest Whitney Oldham, Coalville, Utah, died July 8, 1950, at his home after an extended illness.

Dr. Oldham was born September 15, 1905, in Mendon, Cache County, Utah. He was graduated from Logan High School, the University of Utah in 1928, and from Northwestern School of Medicine in 1932. He taught school for a term in Declo, Idaho.

He interned in the Salt Lake County Hospital,

Salt Lake City, and began practice in the Civilian Conservation Corps.

Dr. Oldham began his Coalville practice in 1934. He was a member of the Salt Lake County Medical Society, the Utah State Medical Association and the A.M.A. He was a member of the North Summit School Board, the Lions Club, the Summit County Wildlife Association, the Summit County Riding Club, the Kappa Sigma Fraternity, and the American Academy of General Practice.

During his terminal illness Dr. Oldham displayed unusual courage, fortitude, and devotion to duty, in the face of what he knew to be certain death. He continued his practice as long as he was able to get around.

He married Ruth McBride on August 3, 1934. Besides his widow he is survived by a son, Whitney, and three daughters, Edmeresa, Mary Lou, and Susanne, all of Coalville.

GARLAND H. PACE

Dr. Garland H. Pace, 1104 East First South Street, Salt Lake City, Utah, died of coronary occlusion July 24, 1950, in a Salt Lake hospital.

Dr. Pace was born in Apache County, Arizona, August 11, 1887. He attended public schools in Thatcher, Arizona, business college in Los Angeles, and was graduated from the Medical College for Physicians and Surgeons, San Francisco, in 1917.

He entered the Army of the United States in World War I and served as a First Lieutenant in the Medical Corps. From 1922-1924 he took postgraduate work training in neuro-psychiatry at Harvard Medical School.

He was superintendent of the Utah State Mental Hospital, Provo, Utah, from 1933 to 1941. After practicing his specialty in Salt Lake City for a year he entered the Army of the United States again in 1942 as a Lieutenant Colonel. At the conclusion of World War II he returned to private practice in Salt Lake City.

Dr. Pace belonged to the Salt Lake County Medical Society, the Utah State Medical Association, and the A.M.A. He was a Rotarian, a member of the Salt Lake Chamber of Commerce, and of the University Club. From 1908 to 1910 he served on a mission to England for the L.D.S. Church.

On September 7, 1911, he married Luella Udall in St. Johns, Arizona.

Besides his widow he is survived by five sons: Dr. Wm. D. Pace, Salt Lake City; Udall W. Pace, Yuma, Arizona; Dr. Joseph L. Pace, San Jose, California; Dr. John G. Pace, Santa Clara, California; Levi L. Pace of Yuma, Arizona; and one daughter, Mrs. Kathryn T. Paul, Redwood City, California.

POSTGRADUATE COURSES IN RECENT ADVANCES IN DISEASES OF THE CHEST

The Council on Postgraduate Medical Education of the American College of Chest Physicians announces that it will sponsor two postgraduate courses in Recent Advances in Diseases of the Chest. The first postgraduate course will be held at the St. Clair Hotel, Chicago, Ill., October 16-20, 1950.

The second postgraduate course will be held at the Hotel New Yorker, New York City, November 13-18, 1950.

Tuition for each course is $50.00. Applications will be accepted in the order in which they are received as registration will be limited.

Address all inquiries and applications to the Council on Postgraduate Medical Education, 500 North Dearborn Street, Chicago 10, Illinois.

MONTANA
State Medical Association

PROCEEDINGS—1950 ANNUAL MEETING, MONTANA STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

The First Session of the 72nd Annual Meeting of the House of Delegates of the Montana State Medical Association was called to order by Dr. F. L. McPhail, Vice President, at 2:15 p.m., July 9, 1950, in the auditorium of the Gallatin County High School, Bozeman.

The Secretary called the roll and announced that there were thirty-one delegates present from twelve component societies, which constituted a quorum. The delegates present were as follows:

Cascade County: F. D. Hurd, M.D., Great Falls; J. C. Wolgamot, M.D., Great Falls; F. K. Waniata, M.D., Great Falls; J. S. Gilson, M.D., Great Falls; E. Hildebrand, M.D., Great Falls.

Fergus County: R. G. Johnson, M.D., Harlowton; J. W. Schubert, M.D., Lewistown.

Flathead County: G. B. Wright, M.D., Kalispell; W. G. Tanglin, M.D., Polson; E. P. Higgins, M.D., Kalispell.

Gallatin County: F. I. Sabo, M.D., Bozeman; R. G. Scherer, M.D., Bozeman.

Hill County: D. S. MacKenzie, Jr., M.D., Havre.

Lewis & Clark County: R. O. Lewis, M.D., Helena; Dean Nichols, M.D., Helena; R. W. Morris, M.D., Helena.

Mount Powell County: G. M. Donich, M.D., Anaconda.

Park-Sweetgrass County: R. R. Means, M.D., Livingston.

Silver Bow County: T. W. Saam, M.D., Butte; J. G. Sawyer, M.D., Butte; R. L. Casebeer, M.D., Butte; H. Stanchfield, M.D., Dillon; J. V. Plett, M.D., Butte.

Southeastern Montana: M. A. Schillington, M.D., Glendive; R. W. Polk, M.D., Miles City; B. C. Farrand, M.D., Jordan.

Western Montana: L. W. Brewer, M.D., Missoula; C. H. Frederickson, M.D., Missoula; Geo. G. Sale, M.D., Missoula.

Yellowstone Valley: L. W. Allard, M.D., Billings; Mary Martin, M.D., Billings; J. I. Wernham, M.D., Billings.

Inasmuch as the minutes of the last session of the House of Delegates were printed in the April, 1950, issue of the Rocky Mountain Medical Journal, the Secretary moved that they be approved as published. There being no corrections or changes, the motion was seconded, voted upon and carried.

The following report of the delegate to the American Medical Association was given by R. F. Peterson of Butte. There being no objection, the report was accepted and placed on file.

The House of Delegates of the American Medical Association met in San Francisco on June 26, 1950. San Francisco put on its finest display of hospitality as well as weather. Addresses by Speaker Borzell, President Irons, and President-elect Henderson were inspirational and should be read by everyone. President Henderson's address was broadcast over a national radio network. These speakers traced the past year in medicine and the progress of the educational campaign of the A.M.A. They discussed the radio and newspaper campaign which is to be conducted in October; and, although a number of delegates were opposed to this type of publicity or education, when all sides of the procedure was explained, when it came up before the House, it passed unanimously for approval. Whitaker and Baxter have been hired for one more year as directors of the educational campaign; but, from now on, the campaign will go on with a decreased tempo. The Hess report, which has to do with hospitals practicing medicine, was remanded to the House from last year's final passage because of possible medical legal difficulties. As it was passed this year, briefly, the Judical Council of the A.M.A. has

jurisdiction over whether or not a doctor is practicing unethically in a hospital. This has especially to do with radiologists, pathologists, anesthesiologists, and physiotherapists; but, especially in the East, has to do with any one of the specialties where some hospitals are now hiring doctors and selling their services. Should the Judicial Council find that a doctor is practicing unethically, they can request the Council on Medical Education and Hospitals to disapprove that hospital. The full details and mechanics of this report are yet to be published. The importance of this problem is evidenced by the fact that the committee took a full half day and the House another full half day in its discussion.

Veterans affairs came in for considerable discussion. It was agreed that there should be more rigid rules for admission to Veterans Hospitals of non-service connected disabilities but agreement was difficult as to the proper procedure. It was suggested that there should be a signature under oath as to the patient's liability for United States income tax before admission to a Veterans Hospital. Alleged abuses by the specialty boards came up for several resolutions. The House of Delegates of the A.M.A. has a large percentage of specialists; but, in thought, they have the feelings of the general practitioner uppermost.

Postgraduate study by doctors has been considered by the federal government to be investment capital and not maintenance of profession. The House agreed that it was maintenance of profession, and that a study should be made so that if so, the expenses of postgraduate study could be deducted from income tax.

Nursing care was the subject of approval for possible inclusion in prepayment plans as was chronic illness which is already in experimentation in certain places. After thorough study, it was thought that federal aid to medical schools should be opposed because, without question, federal control would be inevitable. Each State Society will be allowed 1 per cent or 25c per member for the collection of the national dues from now on. This will also be retroactive and the State Treasurers will be reimbursed for past collections. The $25.00 dues was continued. However, what amounts to a reduction in dues for Fellows of the A.M.A. was the action to include the Journal of the A.M.A. in the $25.00 dues beginning January 1, 1951. A clarification of fellowship and membership will be given to the House by a special committee in December of 1950. This will also include whether or not a Fellow can subscribe to one of the special journals instead of to the Journal of the A.M.A. as a proviso of membership or fellowship. Dr. John W. Cline of California was unanimously elected President-elect for next year. We are enthusiastic about him. The registration at this session was 10,119; 34 of whom were from Montana. The 1951 session will be in Atlantic City; 1952 in Chicago, and 1953 in New York City. The interim session, which was scheduled for Denver in December, 1950, had to be moved to Cleveland at that date because Denver's auditorium was being rehabilitated and a strike by craftsmen caused a delay in its completion.

The report of the Nominating Committee was the next order of business. Dr. J. H. Garberson, Chairman, read the following slate of officers for 1950-51:

For President-elect: F. L. McPhail, Great Falls, and W. E. Harris, Livingston.
For Vice President: James M. Flinn, Helena, and C. W. Lawson, Havre.
For Secretary-Treasurer: H. T. Caraway, Billings.
For Delegate to the A.M.A.: R. F. Peterson, Butte.
For Alternate Delegate: Thos. L. Hawkins, Helena.
For Executive Committee: Thos. F. Walker, Great Falls, and Thos. L. Hawkins, Helena.

The Chair then called for nominations from the floor. Dr. R. E. Seitz, Bozeman, was nominated for President-elect. Dr. George Setzer, Malta, was nominated for Vice President. Dr. R. O. Lewis, Helena, was nominated for Delegate to the A.M.A.

After being read by Dr. H. T. Caraway, the following report of the Secretary-Treasurer was placed on file, there being no objection:

Your Secretary's office has been a busy one during the past year. The obligation placed upon us by the House of Delegates last year to assist the Executive Committee in finding a man for the potential job of Executive Secretary, together with the mounting demands of the A.M.A., Whitaker & Baxter, and our own public relations work, has taken so much of your Secretary's time that his own personal work in his office has been grossly neglected and it would have been impossible to devote as much time to the medical association if your Secretary had not been associated with men who understood and took part of the load. Of course, this cannot and will not continue. Mr. Hegland must be designated as Executive Secretary now in order that he may properly assume the major part of the work and in order that your Secretary can give the necessary amount of time to the practice of medicine and try again to uphold his part of the work load in his group. We hope that the House of Delegates will see fit to amend the By-Laws to make it possible to designate an Executive Secretary at some early date.

Our association is in excellent shape, both financially and from the standpoint of activities in cooperation with our parent body and our National Education Campaign directors, Whitaker & Baxter. The total state dues paid in 1949 was 432. At the present time, 413 physicians have paid their 1950 state dues. There are still thirty-seven physicians who were members last year that have not paid 1950 dues. We anticipate that their dues will be forthcoming before the end of the year. In addition, we have thirty inactive members. A.M.A. dues for 1950 have been paid by 331 Montana physicians at this time.

What amounts to a reduction in the A.M.A. dues for 1951 is that payment of the $25 dues to the A.M.A. will include a subscription to the Journal of the A.M.A. This really reduces the dues to $12.50 since the subscription to the Journal is $12.50.

Your Secretary's office has been able to put out considerably more work since Mr. Hegland came because of his assistance. It has been possible to mail out some 500 letters in cooperation with Whitaker & Baxter to various groups, asking them to pass resolutions opposing compulsory health insurance. Included in these groups are the American Legion, American Legion Auxiliary Veterans of Foreign Wars, Business and Professional Women's Clubs, Amvets, etc.; all on the state level.

The arranging and promotion of a Montana Conference on Physicians and Schools was possible only because of the presence of Mr. Hegland to plan all of the details involved in this endeavor. The conference was a success from all angles and we have received several letters congratulating the association on having taken this initial move.

Our office has contacted, by wire and letter, all of our Senators and Representatives as well as those from surrounding states, on several bills before Congressional committees and on the floor of the Senate and House. We have attempted to keep abreast of the current doings on legislative matters and to keep our Senators and Representatives cognizant of the views of our state association headquarters on current legislation. Our office was active in supporting the Montana Chamber of Commerce in its opposition to Federal usurpation of state water rights.

Your Secretary was in attendance at the Montana Public Health Association meeting, held jointly with the Rural Health Conference, in Billings, and was privileged to give to that group a paper on the supply and distribution of physicians in Montana.

Your Secretary, together with Mr. Hegland, attended the annual session of the American Medical Association in San Francisco, and we are happy to report that the tempo of aggressiveness of the A.M.A. has considerably increased during the past year and we can look forward to a vigorous program on the part of our parent organization under the leadership of Dr. Henderson this year and Dr. John Cline of California, next year, who was elected President-elect. Dr. Henderson you all know, and many of you know Dr. Cline as a most aggressive person and one who stands for the things we would wish the President of the A.M.A. to stand for. He is of the younger group of the House of Delegates and a most progressive and enlightened man. We think a congratulatory telegram authorized by this House of Delegates on his election is in order.

Whitaker & Baxter came in for considerable congratulatory comment at the meeting of the A.M.A. and the recent resolution on the part of the Board of Trustees to engage in a nation-wide advertising campaign is apparently off to a flying start.

We can congratulate ourselves in this state on having such a person as Dr. Ray Peterson as our delegate to the House of Delegates of the A.M.A. Although Dr. Peterson has been there only a relatively few sessions, it is amazing the number of contacts he has made, influential people he has become acquainted with, and the number of delegates who seek him out for his opinion on many matters up for discussion before the House. It is

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your Secretary's hope that this House will not see fit to change our delegate unless it is necessary to do so. It takes several sessions before a delegate is much of note, and therefore, it is to the advantage of a state to keep a delegate in the House as long as he is able and willing to serve. His seniority from the standpoint of influence in the House increases in direct proportion to the length of time he is there.

It was a disappointment to many of us to learn that the next Interim Session of the American Medical Association cannot be held in Denver as it was planned. Due to recent labor troubles there, it will be impossible to hold such a large meeting in Denver because of their inability to complete an auditorium, now in process of remodeling, in time for the meeting. Therefore, the next Interim Session of the A.M.A. will be held in Cleveland instead of Denver. The next annual sessions of the A.M.A. will be held in Atlantic City on June 11 to 15, 1951, and in Chicago on June 9 to 13, 1952.

The Treasurer's report has been submitted to the Audit Committee and suffice it to say here that our financial condition is good. The Executive Committee has approved a budgeting of our funds, and we hope that this will make for a more orderly and efficient use of the funds available to the Secretary-Treasurer in the administration of the office.

It has been a pleasure and a privilege to have served you as Secretary-Treasurer during the past year.

The Chair then suspended the order of business and asked Dr. H. T. Caraway to assume the chair. Dr. McPhail then gave his report, as acting President, to the assembled delegates. There being no objections, the following report was placed on file:

This year the Montana State Medical Association has been unfortunate in not having Dr. Tom Walker in good health, and, as a result we have missed his experience in the supervision of the affairs of our association. Your Vice President has attempted to present to him all of the problems which have come to the attention of the Executive Committee. It was nevertheless impossible for Dr. Walker to put into effect some of the excellent plans which he had worked out for this year. Out of the various conferences held with Dr. Walker we arrived at some recommendations for the future years.

It is recognized that our profession has a considerable problem if we are to consolidate public opinion in our favor. Our national association has done a good job in so far as present public opinion is concerned. In addition we have been fortunate in our efforts to control legislation. However, we cannot maintain our position by killing bills. We must, in addition, recognize community health problems and be willing to discuss these problems with the public and assist them in arriving at the best solution. If, in each community we can handle the various health problems as they arise, and if we can satisfy the people in those communities in their desire to improve health conditions, then we can surely say that we are working well with the people and that we have their confidence. This will in turn give us the best public relations money can buy.

The doctors can do a great deal to improve public relations by paying particular attention to the following problems:

1. **Fees.** The incidence of excessive fees is fortunately not common in Montana. If one doctor is guilty, the entire profession may be blamed.

2. **Blue Shield.** We must continue to improve the contracts available to the people in our sponsored program, and by the same token we must try and avoid situations which will lead to ill will and as soon as possible eradicate from the contracts any such provisions.

3. **Medical Education.** It is very difficult for a Montana boy to gain admission to a medical school. We must take an interest in this problem and make an effort to make it possible for some of our young people to obtain admission to some medical school. A consideration of this problem will be presented to this assembly.

4. **Public Health Department.** This association has done a great deal in the past three years to develop a modern Public Health Department in the state. There have been many handicaps, chiefly our low salary schedule. Three of our members were appointed to the new State Board of Health, and they accomplished a great deal. A new salary schedule has been approved. Dr. Carlyle Thompson has been appointed Health Officer for the state. Your Vice President requests that the doctors of the association make every effort to get acquainted with him and help him in his problems. He stands ready and is anxious to assist the doctors in their problems. He will be introduced at this meeting and it is our hope that all of you will meet him and get to know him.

5. **The establishment of a Public Health Advisory Committee.** A great many of our main committees are concerned in some way with the state Board of Health. Nearly every state society has such a committee. It is suggested that a new committee be appointed to act in this capacity. The chairmen of all interested committees could be named to this committee with one of the Executive Committee acting as chairman.

6. **Local Health Units.** Many years ago the A.M.A. took a positive stand and urged that each state should have a public health department. Now the A.M.A. has come out in favor of local health departments. There is considerable discussion in some parts of the state in regard to this problem. In some parts of the state some doctors are either passively or actively opposing a desire on the part of the laity to develop local health units. In other areas doctors are actively helping their community to find the program best suited to their needs.

7. **Physicinn School Conference.** The A.M.A. has held such conferences for two years, the first in 1947 and the second in 1949. The purpose of these conferences is to hold joint meetings of doctors, dentists, public health personnel, and public instruction personnel. The Dental Association of Montana has already accomplished a great deal in this regard. They have a policy set up and are attempting to cooperate with each school system. Early this year the Montana State Medical Association was asked by the A.M.A. to put on such a conference. The idea was approved by the Executive Committee, but before broaching such an important program, representatives from the component societies were consulted, with the thought that such a conference would not be attempted unless these doctors approved. The Auxiliary was also asked to cooperate. There were about 42 people at that meeting and it was voted to approve a physician-school conference. The conference was held on June 20 of this year and the attendance was gratifying.

There were 217 registered; of these, 28 were doctors, five dentists, 14 county superintendents of schools, 19 city school superintendents, 25 teachers, 21 local public health nurses, four from the Woman's Auxiliary, and many other organizations were represented.

The conclusions of the conference were simple. There were four sub conferences and these all came out with about the same recommendations. The major first recommendation was that a health council should be organized in each community with the approval of the State Medical Association and that the doctors, the teachers, and the public health people in each community cooperate in discussing the health needs in their community and mutually arrive at a solution for these needs. The health service conference headed by Dr. Frederickson made some specific recommendations which will be included in a special report of the conference. It was voted by those attending the conference that the medical association be requested to put on a similar conference next year.

The finest opportunity for excellent public relations is presented to the medical association at this time. Through efforts to improve public health in the state we can develop a very friendly feeling on the part of the people in every community toward their doctors and, most important, toward their doctors' organization. You all know and recognize that the doctors as individuals have always been held in the highest esteem, but that the doctors' organizations have not been treated so kindly. This is chiefly because for so many years we held ourselves aloof and were inclined to be opposed to most new ideas.

We are in a position now to meet with the people in our communities and to talk over health problems with the same people we are treating as patients. We may discuss public health. We should be well informed. Public health medicine is not socialized medicine and never will be unless we help make it so. Public health practices have always developed more work for the doctors rather than taking it away from them.

It is the hope of Dr. Walker and of your Vice President that members of the Montana State Medical Association will heed this important consideration and take an active interest in the medical needs of each community. If all problems are referred to a committee of the component medical society in the area concerned, any decision will be the policy of the society rather than a snap decision by just one doctor. The state society should approve general public health policies and give to

a public health committee sufficient power to assist local societies in policy making.

Your Vice President wishes to recognize an excellent Executive Committee. There have been many meetings this year. These meetings have required considerable travel and time. The progress this year would not have been possible had it not been for the utmost cooperation from this group of seven doctors.

Mr. Hegland has made our work much easier. The many details and the planning which becomes more complicated each year have been handled efficiently. He made the Physician-School Conference possible. The meeting was well managed and well planned. The medical association received many congratulatory letters. To Mr. Hegland we owe our gratitude.

Finally, we owe a great deal to our Secretary. Dr. Caraway has given untiringly of his time, many times at great personal expense, to further the Montana State Medical Association. Your other officers may come and go, but without a good Secretary this organization or any other organization will cease to exist. We have a great Secretary. He has done a fine job. Through his efforts the Montana State Medical Association has grown in stature. If we all follow this example, the association should be a potent force for the finest public relations attained by any society.

The following report of the Executive Committee was read by Dr. H. T. Caraway and placed on file.

Since the last Interim Meeting of the association in January, the Executive Committee has held several meetings to transact certain business which required immediate action. The following represents some of the more important actions and are presented here for the information of the House.

Budget. At the meeting held on March 26, the Executive Committee adopted a budget to regulate the expenditure of association funds. This is the first year during which the association has operated under a budget. It should prove a definite advancement and provide orderly and proper disbursement and receipt of monies. It is expected that the committee will be able to present to the House of Delegates, in the future, a fairly accurate estimate of receipts and disbursements as experience is gained.

Contribution to Public Health League of Montana. By agreement of the Committee and representatives of the Public Health League, it was determined that the association would remit $5.00 per member in good standing to the Public Health League of Montana, rather than $7.00 as heretofore. This reduced remittance was made possible because of the fact that members of the Montana State Dental Association are now contributing an equal per capita amount.

Executive Officer to State Board of Health. Following the resignation of Dr. B. K. Kilbourne as Executive Officer of the State Board of Health, your Executive Committee met with members of the Board and Governor Bonner to discuss the appointment of a new Executive Officer. As a result of this conference, the Board was authorized to engage an individual for this position at a substantially higher salary than had been offered heretofore. It was apparent that if a well-qualified individual was to be obtained for this position, it would be necessary to offer him an adequate salary. Recently the Board engaged Dr. G. D. Carlyle Thompson from the Oregon State Board of Health. Dr. Thompson will assume his duties on September 1st and it is the hope of the Executive Committee that during the next few months he will be able to visit each of the component societies to acquaint the membership with the plans and programs of the Board.

It is the recommendation of your Executive Committee that a new committee to be called the Committee on Public Health be authorized by an amendment to the By-Laws to act in a liaison and advisory capacity to the Executive Officer of the State Board of Health. This committee should consist of the chairmen of the following committees:

Interprofessional Relations
Cancer
Maternal and Child Welfare
Tuberculosis
Fracture and Orthopedic
Rural Health
Industrial Welfare
Rheumatic Fever and Heart
Emergency Medical Service
Industrial Accident
Hospital Relations
Mental Hygiene

The President-elect of the association should be named chairman of this committee so that he may have an opportunity to become better informed on the committee activities of both the association and the Board of Health.

Rural Health Conference. With the approval of the House of Delegates the Secretary's office actively supported and publicized the joint meeting of the Montana Public Health Association and the Rural Health Conference, which was held in Billings May 2 and 3, 1950. The medical profession and the association was well represented at this meeting and all physicians took a very active part. Dr. B. C. Farrand served the Montana Public Health Association as President during the past year and is to be highly commended for the accomplishments of his administration. Dr. M. A. Shillington was elected Vice President of the Public Health Association at this meeting.

Montana Conference on Physicians and Schools. With the authorization of the Executive Committee and the support of representatives of each of the component societies, a conference on physicians and schools was held in Helena on June 20, 1950. This conference was exceptionally well attended by 217 individuals interested in the health of the school child. The conference adopted a number of broad general recommendations, but there are only two that need concern the House at this time. One is that a record of the recommendations of each of the discussion groups be sent to all of the component societies of this association for their information. Probably a complete report of the conference including the statements made by the speakers, the summary of the discussion in each group and their recommendations, could be published. Such a published report could then be distributed to all individuals and organizations interested in this subject. The second recommendation, which was approved by the entire group at the conclusion of the conference, was to the effect that another meeting on physicians and schools should be held in late spring or early summer of 1951. The Executive Committee suggests that the House of Delegates approve these two recommendations which have been forwarded to us for action as a result of the conference.

Nurses Education Program. The Executive Committee has expressed the willingness of the association and particularly the Interprofessional Relations Committee to cooperate with university authorities in improving courses for the training and education of nurses. We anticipate that in the coming months a close working relationship will be established.

Orderly Rotation of Annual Meetings. Because of the heavy convention schedule in most of the larger Montana cities and because of the importance of advising exhibitors several years in advance of the dates and place of the annual sessions of the Montana State Medical Association, the Executive Committee recommends to the House of Delegates that these annual meetings rotate between the following cities: Great Falls, 1951; Missoula, 1952; Billings, 1953; Butte, 1954; Bozeman, 1955; Great Falls, 1956; etc. The committee also recommends that it be empowered to select the dates of each annual meeting as far in advance as possible. Under the proposed plan, the city of Helena will not be used by the association as a place for the annual meetings. It will, instead, continue to be designated as the location of the Interim Sessions.

Provision for an Executive Secretary. A year ago the House of Delegates authorized the Executive Committee to engage a Public Relations Director who would at a future date become Executive Secretary. Since this authorization was given to the Executive Committee it has engaged Mr. Hegland. The committee now recommends that the By-Laws be amended to provide for an Executive Secretary and that it be empowered at this time to name Mr. Hegland to this position.

Legislation for Medical Education. Inasmuch as the State of Montana, because of its small population and limited financial resources, is unable to provide a university or college for the training of physicians and inasmuch as other states have entered into agreements with medical schools already established, it is the recommendation of the Executive Committee that the House of Delegates authorize the Legislative Committee to draft legislation which will permit qualified Montana students to matriculate at such schools upon payment of appropriate fees by the proper agency of this state. Not long ago the Wyoming Legislature adopted such an act under which the Trustees of the University of Wyoming are authorized to offer and provide training and education in professional health services and to enter into contracts with other institutions within or without the state for this purpose.

Resolution from National Association of Boards of Pharmacy. Recently the secretary of the National Association of Boards of Pharmacy requested that the governing body of this association consider and act upon a resolution condemning physician-owned clinic pharmacies as unethical, unwarranted and detrimental to good medical and pharmaceutical service. Your Executive Committee recommends that this resolution be endorsed by the House of Delegates.

Reincorporation of the Association. Because of the expiration of the corporate life of the Montana State Medical Association, the Executive Committee strongly recommends that the House of Delegates adopt a resolution which will authorize the officers to proceed to incorporate as a non-profit corporation.

Montana Chamber of Commerce. The Montana State Chamber of Commerce has been very active in its support of the medical association and has cooperated to the greatest extent in combating legislation contrary to the best interests of the medical profession. The Chamber of Commerce has requested that our association officially endorse and approve their organization and it is the recommendation of the Executive Committee that this House of Delegates officially approve this request. Each delegate, it is believed, has received a packet of information about the more important affairs of the Chamber of Commerce.

Because of the important work of this organization, the Executive Committee also recommends to the House of Delegates that the association be authorized to become a member of the Chamber of Commerce at the regular membership fee of $25 per year.

Resolutions. At the annual meetings of many state associations resolutions have been adopted by the governing bodies supporting the study and recommendations of the Hoover Committee on Government Expenditures. In addition, state medical associations are reaffirming their opposition to compulsory health insurance. Your Executive Committee has prepared similar resolutions for the consideration of this House of Delegates and heartily recommends their adpotion.

The Executive Committee also recommends to the House of Delegates the passage of a resolution opposing Reorganization Plan No. 27 by urging support of Senate Resolution 302 and House Resolution 647.

Dr. McPhail announced that the recommendations of the Executive Committee included in the report would be acted upon at a later time. Dr. Caraway then read the two proposed amendments to the By-Laws for the information of the delegates and to comply with provisions of the By-Laws that any proposed amendments must lie on the table for 24 hours before action is taken. These amendments proposed the establishment of a Committee on Public Health and provisions for the appointment of an Executive Secretary for the State Medical Association.

The following report of the Rheumatic Fever and Heart Committee was given by Dr. F. R. Schemm, Chairman. The committee made no recommendations at this time, and there being no objection, the report was placed on file:

Your committee wishes to make a brief report on the progress of the Cascade County Pilot Program for Rheumatic Fever. The State Board of Health did not give the necessary activating approval for this program until April, 1950. The Pilot Program Committee of the Cascade County Medical Society had been ready for months. Two clinics have been held in the offices made available by the County Health Office at the Civic Center; one on June 7th and one on June 14th.

The Cascade County Pilot Program Committee, consisting of Drs. Tom Walker, Jr., Chairman, J. S. Gilson, Mary McLaughlin and Frank J. Friden, had felt that the program should be started with a minimum of publicity and with a maximum of thoroughness for each case. The patients seen have been carefully restricted to cases of rheumatic fever known to the County Health and Welfare Departments. In each case letters have been written to the attending physician.

The Cascade County Medical Society first approved the Pilot Program in 1949. At this time an Advisory Committee was set up consisting of Drs. John M. Hickes, Chairman, J. C. Hanley, C. E. Magner, Thos. M. Keenan and John F. McGregor. Its function is to advise promptly of any difficulties that may arise between patients seen at the Clinics and their attending physicians, and to make suggestions about the Pilot Program.

Because of the long delays which occurred, and which were to be expected in starting a program of this nature, and because of the fact that only two Clinics have been held, no statistical data is available. No recommendations are being made to the House of Delegates at this meeting regarding the program because of the short duration of its operation. It is expected that recommendations will be made at the Interim Session.

Dr. I. J. Bridenstine, Chairman, read the following report of the Legislative Committee. There being no objection, the report was placed on file:

Your Legislative Committee has considered only two pieces of State legislation that will be likely to come up at the next session of the Montana State Legislative Assembly.

1. The Nurses Bill. This bill provides for registration and licensing of practical nurses, with sections describing the requirements for licensed practical nurses as to training and experience. It also reorganizes the State Board of Nurses Examiners to provide for representation on this Board for the practical nurses. A similar bill was introduced at the last session of the Montana Legislature, but was not passed, there being much disagreement between the practical nurses and the registered nurses before the Committee that was handling this legislation in the State Assembly. Your Chairman has been assured by the representative of the State Nurses Association that all of the difficulties over which there had been disagreement have been smoothed out.

As to the bill itself—it seems to be a good one. Some objection was raised by one member of this committee in regard to the requirement of two years of High School as a prerequisite for the licensed practical nurse. He felt that this might keep some very able women from being licensed because they had only an eighth grade education. It is the feeling of your committee that the medical association should have very definite assurance, both from the registered nurses and from the practical nurses groups, that they are in full agreement on this bill before backing the bill when it is to be introduced at the next session of the Legislature.

2. The model bill on changes in expert testimony in our courts. This is a Montana State Bar Association Bill and provides for a set-up whereby a judge can appoint totally disinterested expert witnesses in any trial where expert testimony is to be introduced; these experts to be appointed by the judge, agreeable to both litigants; and the expert to be classed as a "friend of the court." This seems to be a good bit of legislation and your committee recommends that the Montana State Medical Association approve of the bill.

No other legislative matters have been referred to this committee. Three other items of concern to the Montana State Medical Association will require attention during the next few months:

1. Something will have to be arranged for giving our Montana girls and boys an opportunity to attend medical schools. It is becoming very difficult for our students to gain admission to the medical schools of the nation. Some sort of tie-up between our College and University and one or more recognized medical colleges should be arranged.
2. More work is needed in connection with our laws on adoption procedures.
3. More money is needed for the State Board of Health and an effort to secure a larger appropriation at the 1951 Session of the State Legislature should be made.

The report of the committee was placed on file, in the absence of objection, and the recommendations of the committee were considered separately.

Dr. Bridenstine moved that the Montana State Medical Association approve the nurses bill and cooperate with the registered nurses and the practical nurses groups in establishing this measure as part of the Montana laws. The motion was seconded and after brief discussion was carried.

Dr. Bridenstine moved that the Montana State Medical Association approve the model bill on expert testimony and cooperate with the Mon-

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[1]Cooke, R. A.: *Allergy in Theory and Practice.* Philadelphia: W. B. Saunders Company, 1947, p. 186

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tana State Bar Association in establishng this measure as a part of the Montana laws. The motion was seconded and carried.

The report of the Necrology and History of Medicine Committee was given by Dr. L. W. Brewer, Chairman. There being no obpection, the report was placed on file.

Since our last meeting, two Montana physicians have died. These are Dr. Tom Moore, Sr., previously a member of the Silver Bow County Medical Society, more recently retired and living in Somers, and Dr. Thomas L. Cockrell, of Hinsdale.

Be it recommended that this committee be instructed to express to the surviving families of these two Montana physicians the sincere sympathy and condolence of the members of our association, and our appreciation of their professional and personal services to the people of their communities.

Be it also recommended that in honor to these men, the expression of sympathy and appreciation be made a part of the permanent record of the Montana State Medical Association.

With respect to the proposed medical history of Montana, the committee wishes to report that the incomplete manuscript has been in the hands of Dean "Burly" Miller of the Montana State University Department of History since our last meeting. Dean Miller wishes to report that a careful study of this material has been conducted, and that he feels there is a fair amount of valuable material in form which can be used with little revision. However, the larger portion of the present manuscript will require not only verification, but a great deal of editing and revising.

Dean Miller recommends that we continue the project. The best way to handle it will be to secure a graduate student who will undertake the history as a thesis.

At the present time, there is prospect of a suitable graduate student who might be available to start work this fall. Including the time necessary in verifying the material and correlating and writing it, Dean Miller feels two to three years may be required.

Financial arrangements will be dependent at least in part on the identity of the person who eventually is selected to do the work. As to the publishing costs, it is not practical at the present time to enter any negotiations, or ask for bids from any publishing house.

In order to advance the progress of the proposed history, your committee wishes to recommend that it be authorized to negotiate with a graduate student to be selected by Dean Miller and his staff, for an outline for the publication, together with a time-table for its expected completion.

To reimburse the student for surveying the project, and more particularly to insure prompt results, the committee recommends that it be empowered to spend up to one hundred dollars, as may prove necessary, between now and the interim meeting in 1951.

Dr. J. H. Garberson moved that the House of Delegates authorize the expenditure of not more than $100 to further the work of the Necrology and History of Medicine Committee in the preparation of a history of medicine in Montana, as recommended in the report of this committee. The motion was seconded and carried.

The following report of the Public Relations Committee was then read by Dr. H. T. Caraway, Chairman. There being no objection, the report was placed on file.

At the Interim Meeting of the House of Delegates in Helena last January, the Public Relations Committee was instructed to study the advisability of establishing a Grievance Committee and to develop a plan for the formation of such a committee if it seemed desirable. Your Public Relations Committee met in Helena last April to consider this question and to thoroughly explore the advisability of establishing such a standing committee.

This committee first reviewed the plans adopted by other state associations and studied the effectiveness of their plans to adjudicate complaints between the physician and his patient. Probably the first state to establish a Grievance Committee was Colorado and they have found the idea very effective. It is the opinion of their House of Delegates and all of their officers that "this modernized system of self-discipline has proved itself. It has performed a worthwhile public service, and secondly, it has worked wonders for the profession's public relations. Colorado recommends the plan confidently to every other state medical society, with appropriate modifications." (Excerpt from a report of H. T. Sethman, Executive Secretary, Colorado State Medical Society.)

It is the opinion of your Public Relations Committee that the designation of a Grievance Committee gives the wrong implication as to the problems of grievances and, therefore, they recommend that such a committee be known as the Mediation Committee of the Montana State Medical Association, inasmuch as the definition of "mediation" is: To interpose between parties as the equal friend of each, especially, to effect a reconciliation.

In the belief that the establishment of a Mediation Committee will materially promote and improve relations between the medical profession and patients, this committee recommends that such a committee be formed by the approval of this House.

The suggested committee will only consider complaints received from lay people concerning professional conduct or professional services. These restrictions were placed upon our proposed Mediation Committee because in the opinion of this committee, the disputes between physicians themselves are properly handled by the Council which is established under our Constitution and By-Laws as the Board of Censors and judicial body of the association. We feel it is important, too, to understand that the proposed amendment merely authorizes the appointment of a Mediation Committee. It does not establish the rules and regulations governing the procedures to be followed by the committee. Instead, it instructs the committee to establish its own rules which must be approved by the Council before their adoption by the Mediation Committee. In this manner it should be able to operate more effectively and will be able to adjust its plans for consideration and settlement of grievances in view of the experience it accumulates without requesting the House of Delegates to revise the By-Laws.

The Public Relations Committee is convinced that it is wise to establish a Mediation Committee and believes that its work can be very helpful to all members of the profession, both individually and collectively.

This committee, therefore, recommends the approval of this report and the adoption of the proposed changes in the By-Laws by this House of Delegates.

Dr. Caraway then read the proposed amendment to the By-Laws to provide for the establishment of a Mediation Committee for the information of the delegates and to comply with provisions of the By-Laws that proposed amendments be tabled for twenty-four hours before action thereon.

The report of the Council of the Montana State Medical Association was read by Dr. G. B. Wright, duly elected representative of the Council, and placed on file:

The Council of the Montana State Medical Association was called to order by Dr. F. L. McPhail, Vice President, at 1:15 p.m., on July 9, 1950.

After a brief discussion of the duties of the Councilors for the benefit of new members on the Council, it was moved, seconded and carried that Dr. G. B. Wright be elected to make the report of the Council to the House of Delegates.

The matter of legal counsel for the Montana State Medical Association was considered and Dr. H. W. Gregg moved that Mr. E. G. Toomey of Helena, who has been retained for the past several years as the legal counsel for the State Medical Association, be retained for the coming year at the same retainer fee as in the past year. The motion was seconded and carried.

The establishment of a Mediation Committee was discussed in detail and upon motion by Dr. H. W. Gregg, seconded and unanimously carried, the Council approved and recommended the establishment of a Mediation Committee. This was considered to be a matter of good public relations.

There being no further business to come before the Council at this time, the meeting was declared adjourned at 1:45 p.m.

The Legal Affairs and Malpractice Committee had no report. Dr. H. T. Caraway read a letter from Dr. A. L. Gleason, Chairman of this committee, advising that no business had come before the committee for their attention.

Dr. H. W. Gregg, Chairman of the Program Committee, advised that his committee had no

formal report to make at this time. Scientific programs for the two meetings this year were the result of this committee's efforts. From the comments received, it was felt that the scientific papers presented by Montana men at the Interim Meeting were very well received. Dr. Gregg also stated that one thing which has come to the attention of the committee during the past year should be discussed, or at least touched upon. That is the fact that the host town putting on the program for the state meeting should have at least one man on the Program Committee so that the host town might have a greater part in arranging the program. The committee felt that this was a very good idea for future consideration.

The report of the Interprofessional Relations Committee was given by Dr. L. W. Allard, Chairman:

The Interprofessional Relations Committee, soon after its appointment, notified the proper officers of the dental, pharmaceutical, hospital and nursing organizations of its existence, and offered cooperation in promoting interprofessional good will and help in matters of public relations and interprofessional problems.

The State Nurses Association invited our participation in the preparation of a bill which is to be presented to the next legislative session. This proposed bill will replace the present Professional Nurses Licensing Act, and at the same time provide recognition and control of the practical nurses organization. This proposed bill sets up a State Board of Registration and Nurses Education, to be made up of five professional nurses and provides that the practical nurses division be represented by three practical nurses. All members of this combined board would be appointed by the Governor.

This proposed bill is similar to those now in operation in most of the states. Members of this committee have reviewed the several rough drafts that have been prepared by the nursing profession and their attorneys, and have met with authorized representatives of the registered and practical nurses groups for a discussion of the provisions in the bill.

The bill itself seems reasonable and timely to us. Both groups of nurses have been working harmoniously together. This bill, because of its help to the medical profession, should be of interest to all of us. We recommend that it be presented to the next session of the legislature and that, with the help of the Legislative Committee who have reviewed the measure, the medical profession use their influence in securing its passage.

The recommendations of this committee were the same as those of the Legislative Committee. Since these proposals had already been acted upon and there being no objection, the report was placed on file.

Dr. Mary E. Martin, Chairman, gave the following report of the Cancer Committee:

Your Cancer Committee met separately three times during the year and three times with the Executive Committee of the Montana Division of the American Cancer Society. Dr. Thos. F. Walker attended the first meeting of the committee.

As a new project this year, the committee proposed through the local cancer committees of the component medical societies an exchange of speakers between four of the societies. These speakers were to speak on cancer, each choosing his own special topic, at meetings to which neighboring medical societies were to be invited. This was to assure that every physician in the state receive an invitation to one of the meetings. Two such exchange programs were held, a group from Western Montana Medical Society speaking in Billings and a team from Yellowstone County Medical Society going to Missoula. Similar exchange is being arranged by the cancer committees of the Silver Bow and Cascade County Medical Societies. The speakers were well received and it is felt that through this plan a Speakers Bureau for appearance before professional groups within the state may evolve.

Serious consideration was given by your committee to organized plans for detection of early cancer in operation in other states, notably North Carolina and Michigan; but it is felt that at the moment the plans in operation elsewhere would require modification and limitation in Montana and that no one of them should be recommended for adoption in Montana at the present time.

An effort was made by correspondence to encourage the appointment of local cancer committees by the component medical societies and to stimulate their activity. Most of the component medical societies have reported active cancer committees. Correspondence with these committees throughout the year urged greater use of the services offered by the Montana Division of the American Cancer Society.

The activities of the Montana Division of the American Cancer Society, with which your committee operates closely as members of its Executive Committee, were, as in the past, in the fields of professional and lay education and service. The only activity which could be classified as research is the reporting program which was continued from previous years. Tabulations of each physician's reported cases are now available upon request.

In the field of professional education there has been added to former projects the placing of nine to eleven authoritative medical texts on cancer in the medical libraries of fifteen hospitals in the state. Such texts are also to be placed with county medical societies having medical libraries. These books, as before, are available from the Headquarters of the Division for loan to individual physicians on request.

Lantern slides, charts and three excellent professional films are also available from the Billings Headquarters and these, after review by a member of your state committee, have been recommended in several letters to the local cancer committees for use in the programs of the component medical societies. Two of the films are being shown at this meeting.

The medical brochures are being sent to those physicians requesting them.

The Montana Division has allocated money for the expense of twenty-five physicians at refresher courses to be given at Portland and Minneapolis. The members of the State Cancer Committee and one physician from each component medical society have been invited to attend the Rocky Mountain Cancer Conference in Denver on the same basis.

Although three out-of-state specialists to visit Montana and speak on cancer were planned for in cooperation with the State Board of Health, only one was brought to the state.

Lay education projects included county training schools for volunteer workers and distribution of additional material in the schools.

The service program was briefly reviewed in the Secretary's Bulletin recently. The newest project is a "sick room service" through which expendable supplies are given and more permanent articles loaned to needy cancer patients upon the request of physicians through local county commanders.

Maintenance aid for patients traveling to centers for treatment is continued and is a much used service. Free biopsy service for indigents is being continued.

A registered nurse has been sent to Memorial Hospital in New York City for a course in "Care of the Cancer Patient," and upon her return will be available in the state for training courses for nurses as well as talks to lay groups.

Financial assistnce to the Tumor Clinic held at St. Vincent's Hospital in Billings has been concontinued. This Tumor Clinic, approved by the Yellowstone County Medical Society, has been visited and approved by a representative of the American College of Surgeons as a Diagnostic and Therapeutic Cancer Clinic.

A grant was given to the Deaconess Hospital of Billings for purchase of laboratory equipment to be used in processing material for histological examination.

In the absence of objection, the report was placed on file and the recommendations of the committee acted upon separately.

Dr. Martin moved that the component medical societies give serious consideration to the establishment of Diagnostic Tumor Clinics and Cancer Clinics as outlined by the American College of Surgeons, and that the possibility of a traveling consultant group or "clinic" be further considered by the Cancer Committee of the Montana State Medical Association. The motion was seconded after a brief discussion of the functions of such clinics and carried.

Dr. Martin moved that the recommendation of the committee to continue the exchange of

speakers on cancer by medical societies within the state be approved. The motion was seconded and carried.

Dr. Martin moved that the Montana Division of the American Cancer Society and the State Board of Health be requested to continue to present authoritative speakers on cancer from outside the state. The motion was seconded and carried.

Dr. Martin moved that the study of established plans for cancer detection in other states be continued by the Cancer Committee of the Montana State Medical Association and an effort be made to outline a plan suitable for Montana. The motion was seconded and carried.

Dr. Caraway read a letter from Dr. F. L. McPhail, Chairman of the Maternal and Child Welfare Committee, advising that no report for the year 1949-50 will be made by this committee. The study of maternal deaths is being continued and will be reported at a dinner meeting of the Montana Obstetrical and Gynecological Society on Monday evening, July 10, 1950, at the Baxter Hotel.

The Tuberculosis Committee had no report.

The following report of the Fracture and Orthopedic Committee was given by Dr. W. H. Hagen, Chairman. In the absence of objection, the report was placed on file.

A meeting of the committee was held on February 5, 1950, in the Capitol Building, Helena, to consult with the Division of Services for Crippled Children of the Montana State Board of Health. Present at that meeting were Dr. Walter H. Hagen, Chairman, Dr. J. C. Wolgamot, Dr. J. K. Colman, who constituted a quorum of the Committee since Dr. G. A. Sexton was out of the state, Dr. L. W. Allard could not attend, and Dr. S. L. Odgers had moved from the State of Montana.

At that meeting the Crippled Children Clinics were discussed and various possibilities were considered in the way of improving service. It was suggested that in view of the great variation in cases in the different counties and areas of the state, that every effort be made to interest the family physicians and the local public health nurses in the finding of cases of crippling conditions. There probably are a number of cases that are not receiving care and do not know of the facilities available to them through the State Board of Health. Drs. B. K. Kilbourne and Belle C. Richards of the Division of Services for Crippled Children discussed other activities such as the problem of completing case records and studying various types of cases handled through the Division of Services for Crippled Children. It was decided that a study of one or another type of case be made in an effort to arrive at some sort of a measure of our success in handling this work. Tuberculosis of the bones and joints was suggested as the first one for study.

The fee schedule of the Crippled Children's Division was also discussed and suggestions made which, it is hoped, will equalize the schedule since a number of procedures are not necessarily orthopedic and some of the work is being done by some of the men in the fields of plastic surgery and neurosurgery.

It was also decided that the Standard Nomenclature of Diseases and Operations would be used to classify cases in the future, as they are diagnosed in the Office of the Division.

The handling of long term and complicated orthopedic problems was also discussed and the following possibilities were brought up: (1) The use of extra beds at Galen for tuberculous cases of the bones and joints, providing that orthopedic consultation is sought and accepted. (2) It is possible that convalescent care for crippled children may be made available in the future. (3) It is also possible that through present hospital facilities this convalescent care can be made available at less expense than average per diem costs.

During the year the committee also investigated and took action in the case of a physical therapist in one city of this state who was prescribing braces on her own, which was thought to be in violation of medical ethics. This has been handled through the Chairman of the Fracture Committee of the Society involved and it is hoped that no repetition of this incident will occur.

The meeting on July 8 was attended by Mr.

from *head* to *toe*

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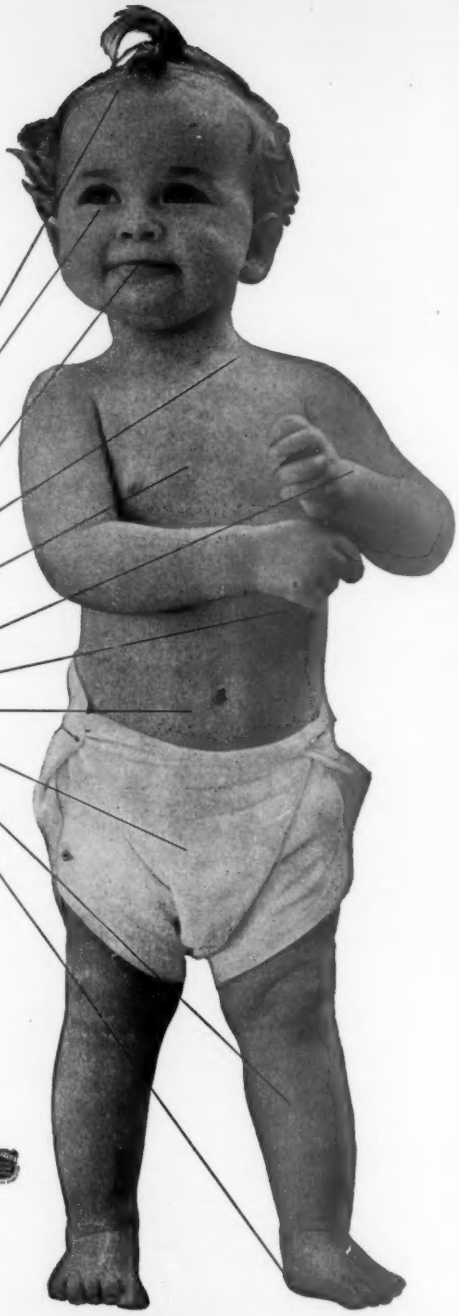

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1. "A Study of Enriched Cereal in Child Feeding" Urbach, C.; Mack, P. B., and Stokes, Jr., J: Pediatrics 1:70, 1948.

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Walter Coombs, Chairman of the Industrial Accident Board. The subject of rehabilitation of the injured was discussed at some length, and it was resolved by the committee that a further meeting will be necessary to consider definite plans to pool our available resources in producing maximum rehabilitation, the so-called "third phase of medicine," which is assuming a vast importance in many parts of the country.

Dr. B. C. Farrand, Chairman, gave the following report of the Rural Health Committee. The report was placed on file, there being no objection.

At the January meeting of the Montana State Medical Association the Rural Health Committee requested that the House of Delegates authorize two members of the committee to attend the National Conference at Kansas City, which was to be held in February, and also that they authorize the committee to hold a joint session with the Montana Public Health Association and try to get Dr. Fred Humphrey to attend the meeting and talk to the group. The House of Delegates very generously cooperated in authorizing both these requests.

Drs. W. G. Tanglin and B. C. Farrand attended the National Conference in February and as before were very much impressed with the interest that was taken in the meeting by both the physicians and the lay groups. We feel that both groups are getting a very worth while education at these meetings, in learning to work together, finding out each others problems, and working out solutions. The lay groups are beginning to realize that they have definite responsibilities in all health problems, and that health is something more than just medical care. The physicians are learning that the public is very interested in health problems, and are very willing to cooperate with the doctors, and that we, as a profession, cannot sit by the side of the road and allow these health movements to gain momentum and develop without our guidance and help. As sure as we do, there will be a group pushing Federal Medicine just waiting to get in and lead these other groups along those lines. We are going to have to make some concessions, but we will still be in the driver's seat.

The joint meeting of the Montana Public Health Association, the Rural Health Committee and the Health Planning Committee was held in Billings the first of May. It was well attended with about 125 being registered. Dr. Humphrey attended, and the American Medical Association paid his expenses. He gave a very good paper concerning rural health problems and what is being done to try to solve them by the medical profession with the aid of all interested persons. He participated in the rest of the conference and was helpful in his suggestions. I think he will give a good report of our activities in Montana to the American Medical Association.

This is the first year that the Rural Health Committee has been able to do anything positive in bringing before the people of Montana the knowledge that the State Medical Association is interested in the health problems of the people and are taking an active part in trying to help them solve the problem. I sincerely hope that it can be continued.

There is a marked tendency over the whole country towards health movements. It seems that every few weeks or months some new group is set up to study some phase of health; and I am wondering if this has not gone to the extreme, not that most of us don't know that improvement is needed in all the different fields of health, but I feel there should be some coordinating agency so that they all could be correlated and receive their proper attention.

The Rural Health Committee would like to recommend the continuance of this committee with the wholehearted backing of the members of the State Medical Association. The committee also recommends the continuance of the yearly meetings in conjunction with the Montana Public Health Association and the Health Planning Committee of the state, with someone who is definitely a representative of the medical association as one of the speakers.

We wish to thank the association and the officers for their help this past year.

The recommendations of the committee were then acted upon and Dr. W. G. Tanglin moved that the Montana State Medical Association continue to sanction the joint meeting of the Rural Health Committee with the Montana Public Health Association and the Health Planning Committee, and that representatives of the medical association be included on the program. The motion was seconded and carried.

The Industrial Welfare Committee had no report.

The Emergency Medical Service Committee had no report.

The following report of the Industrial Accident Board Fee Schedule Committee was given by Dr. Thos. L. Hawkins, Chairman. No objection being forthcoming, the report was placed on file.

As a result of meetings of this committee with the Industrial Accident Board, the following have been accomplished.

1. An increase in the fee schedule. The amount of these increases cannot be definitely stated at this time, but the Industrial Accident Board has agreed to increase many of the items felt low.
2. A physician will be hired by the Industrial Accident Board to scrutinize the bills which come into their office for a better appreciation of the services rendered by the doctors.
3. The Montana State Medical Association will work with the Industrial Accident Board on a plan to establish medical referee examiners. This plan, which will be worked out in the future on a practical basis, will present to the Industrial Accident Board unbiased and impartial medical examination and establishment of disability for the information of the board itself. This procedure would in no way interfere with the hearings or the presentation by either litigants or expert witnesses to establish or defend their position.

The recommendations of the committee were then acted upon. Dr. Hawkins moved that the House approve the recommendation that a doctor be employed by the Industrial Accident Board to review the claims received by the Board. The motion was seconded and carried.

Dr. Hawkins moved that the House of Delegates approve the appointment of an examining board to be employed by the Industrial Accident Board. The motion was seconded, and after brief discussion, carried.

The following report of the Hospital Relations Committee was read by Dr. Eugene Hildebrand, Chairman. The report was placed on file, there being no objection.

The Hospital Relations Committee has had two meetings during this year. At the first meeting we discussed ways and means of improving the understanding between the hospitals and radiologists, pathologists, anesthesiologists and physical therapeutists—the so-called "hospital specialties." It was decided that we should attempt to have a meeting with a similar committee from the Hospital Association of Montana at which time sub-committee reports on (1) Blue Cross-Blue Shield problems, (2) Problems of the small hospital relative to the "hospital specialties" and (3) Contractual relations could be discussed. This was accomplished through the excellent cooperation of Mr. Richard Lubben, President of the Hospital Association, and the following is a condensation of the discussion:

1. **Blue Cross-Blue Shield Problems.** It was brought out and discussed in some detail that the physician should be paid for his services through the Blue Shield, and the hospital through the Blue Cross. It was agreed that the practice of pathology, radiology, anesthesiology and physical medicine were the practice of medicine. It was further pointed out that the necessary transition in payment to the hospitals and to the physicians to conform to this thinking would be slow, but should be recommended.

2. **Problems of the Small Hospital.** In general, it was thought that standards of service could be elevated by improving the quality of the technical work done. This could be accomplished in several ways, for example: (a) through the employment of better qualified technicians; (b) through proper evaluation of laboratories through the use of known solutions; (c) through more active interest in the small hospital special services by physicians practicing these specialties, to be accomplished on a local level; and (d) through setting up refresher courses for technicians, possibly using the services of a traveling relief technician. This particular problem is being investigated by one member of the Hospital Committee and one member of the Medical Committee. The Montana Society of Technologists was commended for its excellent teaching program at its annual meeting.

3. **Contractual Relations.** Data has been collected regarding contractual relations between pathologists, radiologists, anesthesiologists, and physical therapeutists and hospitals for the guidance of physicians who wish to come to Montana to practice these specialties. It was thought that contractual relations of the physicians with the hospitals should be on an individualized basis.

Recommendations. It is recommended that efforts be continued to work out a satisfactory solution to the Blue Shield-Blue Cross difficulties of radiologists, pathologists, anesthesiologists and physical therapeutists, keeping in mind that these specialties are the practice of medicine.

It is recommended that the Hospital Relations Committee continue to cooperate with the Interprofessional Relations Committee of the Hospital Association of Montana, and that the efforts of this joint action be concentrated on improving the quality of technical work done in the hospitals of Montana.

The recommendations of the committee were then acted upon and Dr. Hildebrand moved that the House approve the continuation of efforts to work out a satisfactory solution to the Blue Shield-Blue Cross difficulties of radiologists, pathologists, anesthesiologists and physical therapeutists, keeping in mind that these specialties are the practice of medicine. The motion was seconded and carried.

Dr. Hildebrand moved that the Hospital Relations Committee continue to cooperate with the Interprofessional Relations Committee of the Hospital Association of Montana, and that the efforts of this joint action be concentrated on improving the quality of technical work done in the hospitals of Montana. The motion was seconded and carried.

The following report of the Mental Hygiene Committee was given by Dr. M. A. Shillington, in the absence of Dr. W. S. Wilder, Chairman. There being no objection, the report was placed on file.

This committee begs to report that it held one meeting at which the problem of mental hygiene was discussed. We were told of the work of the State Medical Hygiene Department. The committee concluded their deilberations with a resolution to make information about the State Mental Hygiene Department available to all the physicians in Montana. A letter was then sent to the secretary of each component society, advising that speakers were available to discuss the activities of the State Mental Hygiene Program. It was recommended that each local society avail itself of one of the speakers. At the present writing, only one county society has asked for a speaker.

Governor John Bonner has interested himself in the welfare of the insane, the mentally defective and in the program of the Mental Hygiene Department. He appointed the Governor's Interim Committee on Mental Health on which committee he placed two of the members of the State Mental Hygiene Committee.

The Governor's committee met at Helena three weeks ago. They discussed the question of housing for the insane and mentally defective at Warm Springs and at Boulder. They also discussed the question of personnel at these institutions and the problems that the superintendents face. They also discussed the extent and scope of the State Mental Hygiene Program. The members of the Governor's committee are visiting both Boulder and Warm Springs. They are preparing, first of all, a budget which will be adequate to bring these institutions up to a national standard. They have also prepared a budget to augment the State Mental Hygiene Program and they are considering legislation to better control the commitment of people to the State Hospital at Warm Springs and the Institution at Boulder. When this legislation and these recommendations are introduced into the Legislature next January, it is quite likely that the aid of all the doctors in Montana will be solicited to use their influence with their legislators to the end that this entire program will be successfully consummated. The Governor has assured us of his wholehearted support.

The following report of the Economics Committee was given by Dr. M. A. Shillington, Chairman. The report was placed on file, there being no objection.

This committee met once and, in addition, has consulted by mail on some of the problems which have been presented. The following are items for your consideration.

1. The Fergus County Medical Society has raised the question of fees for filling out health and accident claims for various insurance companies. It is the opinion of each one in that society that the doctors should be remunerated for this service inasmuch as they are certifying to a physical illness or cause of disability. It is also their opinion that the charge for filling out these blanks should be made to the insurance companies and paid by them. Because this is a state-wide problem they wish it to be discussed by the House of Delegates here at Bozeman.

Three members of the Economics Committee expressed the following: that the matter of collecting fees from insurance companies is a national problem and that the doctors in Montana alone would be unable to force any regulation for payment by an insurance company. They also expressed the opinion that the charge for completing insurance blanks is a just charge against the patient and not against the insurance company. If the House of Delegates feels that this could be carried to a more satisfactory conclusion, the Economics Committee will be glad to proceed to the best of its ability to accomplish your wishes.

2. The committee wishes to report that thirty-four of the major life insurance companies have increased their payment to physicians fifty per cent across the board. In other words, most companies now pay $7.50 for a life insurance examination.

3. The question of uniform insurance disability blanks was presented to the committee by Dr. F. L. McPhail as acting President. The matter was taken up through the American Medical Association in Chicago which has investigated this problem rather thoroughly. The American Medical Association has made some recommendations for uniform blanks. They state, however, that the problem is so complex that they were not able to accomplish anything specific in having their blanks universally adopted.

4. The problem of the displaced physician has presented itself in Montana as it has in every other state. The subject was ably discussed in the Journal of the American Medical Association last June 3rd. The American Medical Association has therein made several recommendations directed particularly at various licensing boards. The problem in Montana is more complicated. Our State Licensing Board has no power or authority whatsoever to change the terms on which doctors are admitted to this state. The terms of admission are prescribed by a law passed by the Legislature. In order that displaced physicians be admitted to Montana, it would be necessary to go before the Legislature with an act to lower our standards of medical practice. This action is undesirable and dangerous. The problem of the displaced physician is a temporary one and lowering our medical standards would be permanent legislative change. The committee strongly recommends against any tampering with the Medical Practice Act.

5. The care of the indigent is no longer the problem that it has been in the past. The Legislature of 1947 passed some regulations which placed the burden of this care upon the county commissioners. Likewise, the welfare boards of the various sections

of the state have been charged with the duty of furnishing adequate care for all persons under their charge. Richland and Cascade Counties have worked out an admirable method for caring for the indigent. Yellowstone County has a method all their own which method still leaves something to be desired in the way of fees. In Dawson County the welfare board is providing money for fees and hospitalization for all those who need it without any specific agreement having been made with the medical profession. The Economics Committee has the following recommendations to make:

1. The incoming Economics Committee keep posted on developments in care of the indigent in different parts of the state and advise the various county societies from time to time as to what is being done.

2. That the county plans be coordinated under Montana Physicians' Service as is being done so beautifully in Cascade County.

3. That actual control of the care of the indigent should be kept at the local level.

6. There being no committee of the state association directly appointed to handle public health matters, the Economics Committee has taken upon itself a recommendation that the doctors in every county in Montana bend every effort toward the establishment of local public health units. The State Legislature has passed bills authorizing, in fact almost directing, the commissioners in every county to set up these public health units. They have even legalized the tax levy for this purpose. Your committee recommends that the physicians of the state get behind their county commissioners and keep them posted on the value of the local health units so that eventually these will be state-wide. There are over two thousand local public health units in the United States at the present time.

The members of the Economics Committee are ready to assist the organization of a plan in any county where their help is desired or needed. The Economics Committee is wholeheartedly in favor of establishing district or county full time health units. This program has gone forward in some counties but still lacks implementation in most of the state.

The recommendations of the committee were then considered. Dr. Shillington moved the adoption of the recommendation of the committee that the incoming Economics Committee keep posted on developments in the care of the indigent in different parts of the state, keeping the various county societies informed; that county plans be coordinated under the Montana Physicians' Service as is being done in Cascade County; that actual control of the care of the indigent be kept at the local level. The motion was seconded and carried.

The agenda for the First Session of the House of Delegates having been completed, the Chair adjourned the meeting at 5:30 p.m.

SECOND SESSION—HOUSE OF DELEGATES

The Second Session of the 72nd Annual Meeting of the House of Delegates of the Montana State Medical Association was called to order by Dr. F. L. McPhail, Vice President, at 2:15 p.m., July 10, 1950, in the auditorium of the Gallatin County High School, Bozeman.

A quorum being present, the Chair proceeded with the business before the House. Dr. McPhail appointed Dr. F. I. Sabo and Dr. L. W. Brewer as additional members of the Audit Committee to assist Dr. R. G. Scherer, Acting Chairman, in the absence of other members of this committee. The Chair requested that the report upon the audit of the books of the Secretary-Treasurer be completed as soon as possible in order that it might be received by the House.

Dr. M. A. Shillington, Chairman of the Economics Committee, moved the adoption of the following resolution:

"RESOLVED: That the House of Delegates go on record as favoring adequate salary schedules to attract highly qualified people in the field of Public Preventative Medicine." The motion was seconded and carried.

The following resolution was read by Dr. M. A. Shillington, who moved its adoption:

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"RESOLVED: That the House of Delegates approve the principle of, and lend the support of the Montana State Medical Association to, the establishing of full time local health units." The motion was seconded and carried.

Dr. M. A. Shillington moved the adoption of the following resolution:

"RESOLVED: That the Montana State Medical Association make application for an Associate Membership in the Montana Hospital Service Association, and that the House of Delegates recommend to their component societies that they likewise apply for Associate Membership in the same association." The motion was seconded and carried.

Dr. T. L. Hawkins moved that the Secretary be instructed to write to Mr. Coombs, Chairman of the Industrial Accident Board, and to Governor Bonner, commending them on their progressive administration. The motion was seconded and carried.

The recommendations of the Executive Committee were read and acted upon at this time. Dr. H. T. Caraway read the following resolution reaffirming the opposition of the Montana State Medical Association to any form of compulsory health insurance and moved its adoption:

"WHEREAS, The Montana State Medical Association in previous Annual Sessions has adopted resolutions opposing the passage of any Federal legislation to provide compulsory health insurance, and

"WHEREAS, The Montana State Medical Association still strongly opposes any form of compulsory health insurance underwritten by the Federal Government for any segment of the American people, and

"WHEREAS, The Montana State Medical Association does heartily endorse the National Education Campaign of the American Medical Association against compulsory health insurance and socialized medicine,

"NOW, THEREFORE, BE IT RESOLVED: That the Montana State Medical Association in Annual Session at Bozeman, Montana, July 9-12, 1950, reaffirms its opposition to all forms of compulsory Federal health insurance or to any system of political medicine designed for National control and regulation and that it again endorses the National Education Campaign of the American Medical Association, and

"BE IT FURTHER RESOLVED: That a copy of this resolution be forwarded to the President of the United States, to the two Montana Senators, and the two Montana Representatives, and to the American Medical Association."

The motion was seconded and carried.

Dr. H. T. Caraway read the following resolution opposing the adoption of Reorganization Plan No. 27 and moved the adoption thereof:

"WHEREAS, The adoption of Reorganization Plan No. 27 would be in direct conflict with the recommendations of the Hoover Commission, and,

"WHEREAS, Approval of this plan would make it almost impossible to create a Federal Department of Health as recommended by the American Medical Association, and

"WHEREAS, Health is a direct concern of every citizen and is entitled to equal Governmental status with Labor and Commerce, and

"WHEREAS, Reorganization Plan No. 27, if adopted, would place the nation's health activities in the hands of a politically appointed Secretary, with no professional qualifications, and

"WHEREAS, The health and welfare of the

American people would not be improved by such action,

"NOW, THEREFORE, BE IT RESOLVED: That the House of Delegates of the Montana State Medical Association in Annual Session in Bozeman, Montana, July 9-12, 1950, expresses its unqualified opposition to Reorganization Plan No. 27, and

"BE IT FURTHER RESOLVED: That the House of Delegates strongly urge Montana Representatives and Senators to vote against the adoption of this plan by voting in favor of House Resolution 647 and Senate Resolution 302, and

"BE IT FURTHER RESOLVED: That a copy of this resolution be forwarded to the President of the United States, the two Montana Senators, the two Montana Representatives and to the American Medical Association and the Association of American Physicians and Surgeons."

The motion was seconded and carried.

Dr. H. T. Caraway moved the adoption of the recommendation of the Executive Committee that the House of Delegates of the Montana State Medical Association heartily approve and endorse the activities and program of the Montana Chamber of Commerce and that it urge physicians individually and collectively to support this organization; also that the House authorize the Secretary to apply for membership of the Montana State Medical Association in the Montana Chamber of Commerce. The motion was seconded and carried.

The following resolution endorsing all efforts to eliminate "waste, duplicity and inefficiency" in the Federal medical services was read by Dr. H. T. Caraway, who moved its adoption:

"WHEREAS, The recent study by the Hoover Commission has disclosed tremendous 'waste, duplicity and inefficiency' in the various medical services of the Federal government, and

"WHEREAS, These services may be easily curtailed without violating the contracts that the Federal government has made with its medical beneficiaries, and

"WHEREAS, The release of unnecessary medical personnel will make these individuals available for civilian practice, and

"WHEREAS, Sound fiscal policies of the Federal government are essential to the economy of the country, and

"WHEREAS, A balanced Federal budget is of primary importance to the economic and social welfare of our democracy,

"THEREFORE, BE IT RESOLVED: That the Montana State Medical Association enthusiastically supports and endorses all efforts to eliminate 'waste, duplicity and inefficiency' in the Federal medical services, and

"BE IT FURTHER RESOLVED: That a copy of this resolution be sent to the President of the United States, the Secretary of Defense, the Director of the Federal Medical Services, to all members of Congress from the State of Montana and to the American Medical Association."

The motion was seconded and carried.

Dr. H. T. Caraway moved the adoption of the recommendation of the Executive Committee that the House of Delegates authorize the Legislative Committee to draft legislation which will enable qualified Montana students to matriculate at medical schools outside of the state upon payment of appropriate fees by the proper agency of the State of Montana. The motion was seconded and after some discussion was carried.

Dr. H. T. Caraway moved the adoption of the recommendation of the Executive Committee

that the House of Delegates authorize the publication of a complete report of the Montana Conference on Physicians and Schools for distribution to component medical societies and other interested organizations and individuals, and that authorization be granted to the Executive Committee to plan and organize another conference on physicians and schools in the late spring or early summer of 1951. The motion was seconded and carried.

The following resolution condemning physician owned clinic pharmacies was read by Dr. H. T. Caraway, who moved the adoption thereof:

"RESOLVED, by the House of Delegates of the Montana State Medical Association assembled in Bozeman, Montana, on July 10, 1950: That it oppose the establishment of physician owned clinic pharmacies as not only grossly unfair to pharmacy and pharmacists, but also as certain to result in resentment upon the part of pharmacists at the very time when conditions are such as to make imperative the utmost cooperation and friendliness between medicine and pharmacy, and

"BE IT FURTHER RESOLVED: That the Montana State Medical Association does at this time condemn physician owned clinic pharmacies as unethical, unwarranted and detrimental to good medical and pharmaceutical service." The motion was seconded and carried.

Dr. H. T. Caraway read the following resolution authorizing the officers of the Montana State Medical Association to proceed to incorporate the association as a non-profit corporation, and moved the adoption thereof:

"WHEREAS, The Montana State Medical Association is a voluntary, unincorporated association, the legislative authority whereof is, by authority of Article V of the Constitution, vested in the House of Delegates, and

"WHEREAS, The House of Delegates is, pursuant to due call and notice, assembled in annual meeting at Bozeman, Montana, with more than two-thirds (⅔) of its total membership present, and there has regularly come before the House of Delegates a proposal to incorporate the Montana State Medical Association as a non-profit corporation, under the provisions of Chapter 283, Laws of Montana, 1947, and said proposal having been considered at length by the House,

"NOW, THEREFORE, BE IT RESOLVED BY THE MONTANA STATE MEDICAL ASSOCIATION, acting by and through its House of Delegates: That the membership of said association hereby authorizes its officers to proceed to incorporate the Montana State Medical Association under such name which is the property of the association, and to do and to take all steps and carry out all proceedings that may be necessary, proper and advisable fully to accomplish incorporation as a non-profit corporation in the State of Montana, including the preparation of Articles of Incorporation, their execution and filing, and to appropriate, hold and exercise all powers and carry out all objects

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and purposes permitted to such a corporation consistent with Chapter 283, Laws of Montana, 1947, and Acts amendatory thereof and supplemental thereto, and in harmony with the professional activities and aims of the association, and the public welfare.

"BE IT FURTHER RESOLVED: That the authority hereby voted shall continue in effect until the Annual Meeting of the House of Delegates in the year 1951, unless sooner exercised and discharged by incorporation."

The motion was seconded and after discussion was carried.

Dr. H. T. Caraway introduced Mr. Mac F. Cahal, Executive Secretary and General Counsel of the American Academy of General Practice, who spoke briefly to the assembled delegates.

The following proposed amendment to the By-Laws to permit the establishment of a Public Health Committee was read by Dr. H. T. Caraway, who moved the adoption thereof:

Under Chapter VI, Section 1, add:

S. Public Health Committee.

Under Chapter VI, Section 4, add:

S. Public Health Committee. This committee shall consist of the President-elect of the association, who shall serve as chairman, and the chairman of the following committees: Interprofessional Relations, Cancer, Maternal and Child Welfare, Tuberculosis, Fracture and Orthopedic, Rural Health, Industrial Welfare, Rheumatic Fever and Heart, Emergency Medical Service, Industrial Accident, Hospital Relations and Mental Hygiene. It shall be the duty of this committee to cooperate with the State Board of Health and to act in an advisory and liaison capacity.

Under Chapter IV, Section 2, Duties of the President-elect, add the following sentence after the words "right to vote."

He shall serve as chairman of the Public Health Committee.

The motion was seconded and the composition of the committee was discussed. Dr. F. K. Waniata moved to amend the motion by adding the words: "and three additional members appointed by the President from the association at large." The amendment to the original motion was seconded and carried. The proposed change in the By-Laws, as amended, was then voted upon and carried.

Dr. G. D. Carlyle Thompson, new Executive Officer of the Montana State Board of Health, was introduced by Dr. McPhail, who read the following editorial from the Oregon Daily Journal, Portland, Oregon:

"Appointment of Dr. G. D. Carlyle Thompson, director of the preventive medical division of the Oregon State Board of Health, to the position of Executive Officer of the Montana State Department of Health, is a deserved recognition.

"Dr. Thompson has done outstanding work in Oregon on maternal and child health and preventive medicine. Montana gains a valuable public servant in its appointment of Dr. Thompson as chief of its public health services. Although Oregon loses his services, it is all in the family. The public health of the Pacific Northwest concerns us all, and it is well that Oregon, with its outstanding medical school, public health system and cooperation of all health agencies, takes the leadership in medicine and public health for this area."

The following proposed amendment to the By-Laws to provide for the appointment of an Executive Secretary was read by Dr. H. T. Caraway, who moved its adoption:

Under Chapter VII, Section 4-A, add the following sentence to the duties of the Executive Committee:

An Executive Secretary may be employed by the Executive Committee, which shall determine his tenure of office and the amount of his salary.

Under Chapter IV, Section 5, add the following to the outline of duties of the Secretary-Treasurer:

The Secretary-Treasurer may, at his discretion,

delegate any or all of the above-listed duties to the Executive Secretary. He shall, however, advise the Executive Secretary on scientific and professional questions and shall assist him in all matters outside the jurisdiction of one not holding the degree of Doctor of Medicine. The Secretary-Treasurer, in case of a vacancy in the office of Executive Secretary, shall assume the duties of that office pending the employment of an individual to fill the vacancy.

Under Chapter IV, add the following new section:
Section 6. The Executive Secretary shall be the executive assistant to the officers, the House of Delegates, the Executive Committee and all other committees. He shall perform also such other duties as the House of Delegates, the Executive Committee or the Secretary-Treasurer may direct. He shall furnish fidelity bond in such amount and in such surety company as shall be determined by the Executive Committee, the expense of which shall be defrayed by this association.

The motion was seconded and carried.

Dr. H. T. Caraway moved the adoption of the recommendation of the Executive Committee that the annual meetings of the Montana State Medical Association be rotated between Great Falls, Missoula, Billings, Butte and Bozeman, and also that the House authorize the Executive Committee to select the dates of each annual meeting at least two years in advance, if possible. The motion was seconded. Dr. Dean Nichols moved to amend the motion by adding the name Helena to the list of cities. The amendment was seconded and during discussion it was brought out that there was no intent on the part of the Executive Committee to prevent any other Montana cities from being host to the annual meetings if they were willing and able to do so. It was felt by the Executive Committee that since Helena had been selected as the site of the Interim Sessions each year, it would be working a hardship to be host to three meetings in succession—an interim, annual and interim—every six years, and therefore Helena was not included in the list of cities. It has become increasingly difficult for the Secretary's office to obtain the maximum number of exhibitors for the annual sessions because of conflicting dates and it was felt that an orderly rotation and advance selection of dates would be a solution to this problem. The delegates were also advised that any other society wishing to be host to the Annual Sessions of the association could submit its invitation two years in advance for the consideration of the House.

The amendment was then voted upon and defeated. Upon being put to vote, the recommendation of the Executive Committee that the meetings be rotated between Great Falls, Missoula, Billings, Butte and Bozeman was carried.

The following proposed amendment to the By-Laws to provide for the establishment of a Mediation Committee was read by Dr. H. T. Caraway, who moved its adoption:

Under Chapter VI, Section 1, add:
K. Mediation Committee. And change the letters preceding the names of the subsequent committees so that they are in proper sequence.

Under Chapter VI, Section 4, add:
K. Mediation Committee. It shall be the duty of this committee to adjudicate complaints received, either verbally or in writing, from any lay person concerning professional conduct or professional services of any physician. This committee shall consist of nine (9) members, who shall be appointed by the President with the approval of the Executive Committee. During the first year of operation of this By-Law, one-third of the committee shall be appointed for a one (1) year term, one-third for

a two (2) year term and one-third for a three (3) year term. Thereafter all appointments to this committee shall be for three (3) year terms. Members of the Executive Committee or of the Council shall not be eligible for appointment.

As soon as practicable after its appointment, this committee shall adopt, with the approval of the Council, rules and regulations to govern its procedure. Any revisions in the rules and regulations of this committee shall be submitted to the Council for approval before their adoption by the committee. Any verdict rendered by this committee after completion of its investigation may be appealed to the Council by either of the interested parties.

Under Chapter V, Section 3, add the following paragraph after the words, "House of Delegates."

The Council shall approve the rules and regulations governing the procedures of the Mediation Committee; changes or revisions in these rules which may hereafter be proposed by the Committee shall also be submitted to the Council for final approval. The Council shall consider any appeal from the recommendations of the Mediation Committee which may be made by either the complainant or the defendant.

The motion was seconded and after discussion, Dr. C. B. Craft moved to amend the motion by deleting the word "verbal." After further discussion and being seconded, the amendment was put to vote and lost. Dr. F. K. Waniata then moved to amend the motion by adding "that the rules and regulations of this committee, after being duly set up, be referred to the House of Delegates at their next Interim Session for approval before the committee becomes active." The amendment was seconded and carried. The original motion, as amended, was then unanimously carried.

The following letter from Dr. Carl L. Larson, Director of the Microbiological Institute of the Rocky Mountain Laboratory at Hamilton, was read by Dr. H. T. Caraway:

"In the course of our studies at the Rocky Mountain Laboratory, it is sometimes necessary for us to obtain samples of blood for serological study from humans suspected of having one of the diseases in which we are interested. In many instances the individual lives at such a distance that it is impossible for us to contact him and we have requested him to go to his local physician to have the sample taken and sent to us.

"We wonder if it would be possible to arrange through the Montana Medical Association to have such patients bled by local physicians free of charge, since we feel that it is unfair for us to ask these persons to provide us with needed materials at a cost to themselves. On the other hand, we have no method whereby we can compensate them.

"We would be most happy to supply franked mailing tubes and Keidel tubes for sending in specimens if the Montana Medical Association agrees to our proposal.

"It has been the custom for some years at the Rocky Mountain Laboratory to provide certain services to the physicians of this state and we hope that they will find it possible to cooperate with us in this problem. We are of course anxious to continue the excellent cooperation we have always had with the medical profession in Montana and are always willing to provide such services as are available at the Rocky Mountain Laboratory."

Dr. H. Stanchfield moved that the House of Delegates approve the request contained in Dr. Larson's letter. The motion was seconded and carried.

Dr. L. W. Brewer reported for the Audit Committee and advised that the books of the association and the audit report prepared by Colberg & Wallin of Billings had been inspected and found to be in order. There being no objection, the report of the Audit Committee was placed on file.

Dr. L. W. Brewer moved the adoption of a resolution to express the appreciation of the association to the retiring President, the Gallatin County Medical Society, the staff and employees of the Gallatin County High School, the Baxter and Bozeman Hotels, and the Program Committee of the association. The motion was seconded and carried.

There being no further new business to come before the House, the Chair declared the annual

election of officers would be the next order of business and appointed Drs. Dean Nichols, C. B. Craft and D. S. MacKenzie, Jr., as tellers and called for additional nominations from the floor. There being none, the nominations were declared closed and the ballots were distributed.

At this time, Dr. W. E. Harris and Dr. R. E. Seitz requested that their names be withdrawn as candidates for President-elect. They expressed the opinion that Dr. F. L. McPhail was a very capable and deserving candidate and asked that a unanimous ballot be cast for him.

While the ballots were being tabulated, Dr. McPhail thanked the three immediate past Presidents, Drs. T. L. Hawkns, L. W. Allard and M. A. Shillington, for their presentation of a gavel to the association. He assured them it would be appreciated by all future Presidents.

The Chair then asked the pleasure of the House regarding approval of the minutes of this annual session. He stated that by the time of the next House of Delegates meeting many new delegates would be present and it would be rather difficult to approve the minutes of this session. He stated a suggestion had been considered that sometime during the proceedings of the next two days a short time could be taken to read the minutes—possibly ten or fifteen minutes at the most—and in that way approved minutes could be published.

Dr. Geo. G. Sale moved that a short session be called for this purpose, either on Tuesday or Wednesday. The motion was seconded and carried.

Dr. Dean Nichols next read the result of the election of officers, which was as follows:

President-elect: F. L. McPhail, Great Falls.

Vice President: James M. Flinn, Helena.

Secretary-Treasurer: H. T. Caraway, Billings.

Delegate to American Medical Association: R. F. Peterson, Butte.

Alternate Delegate: Thos. L. Hawkins, Helena.

Executive Committee: Thos. F. Walker, Great Falls, and Thos. L. Hawkins, Helena.

Dr. McPhail introduced the incoming President, Dr. C. H. Fredrickson, to the assembled delegates and asked Drs. H. W. Gregg and W. E. Long, past Presidents of the association, to escort Dr. Fredrickson to the rostrum to receive the President's gavel.

Dr. Fredrickson thanked the delegates and members of the association for the honor bestowed on him. He promised, for himself and the other officers elected, heartiest cooperation during the coming year. The officers will frequently have to call upon the members for assistance, Dr. Fredrickson said, and he hoped that they would receive much assistance from them in the carrying out of their duties during the coming year.

Dr. C. H. Fredrickson then read the committee appointments that had been completed for the coming year, and advised that the balance would be announced at an early date and all chairmen and members of committees advised of their appointment.

The Chair then declared the meeting recessed at 5:00 p.m., until the time when the minutes of this meeting of the House of Delegates will be approved. The time and place would be announced during the clinical sessions.

* * *

At the conclusion of the presentation of the first scientific paper on Wednesday afternoon, July 12, President Fredrickson polled those present to determine whether or not a quorum of delegates were in attendance to approve the minutes as suggested during the second session on Monday afternoon, July 10. Inasmuch as a quorum was not present, Dr. Fredrickson declared that approval of the minutes would be postponed and the meeting of the House of Delegates adjourned.

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